THE CANADIAN NURSE

L'Infirmière canadienne

VOLUME 51 • NUMBER 1
MONTREAL

Highlight for
JANUARY 1955

GERONTOLOGY

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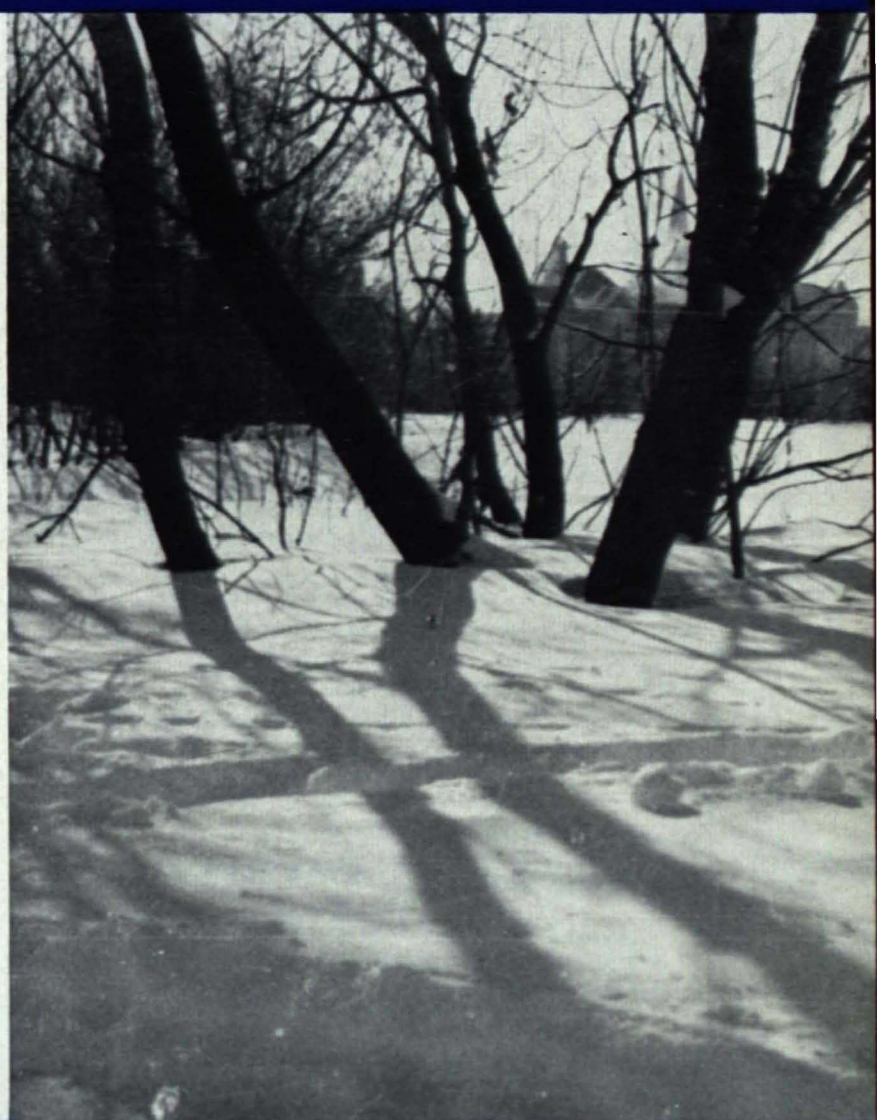
WINTER SHADOWS

•

Courtesy of Miss Jean Whiteford



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Between Ourselves

As President **Gladys Sharpe** *intimates in her New Year message,* nursing in Canada is **on the march** both figuratively and literally. Following the decisions made in Banff last June to draw all the diverse strands of nursing activity into the two main channels of Nursing Education and Nursing Service, it has seemed decidedly anachronistic to maintain the separate page headings that have flourished in the *Journal* for these many years. There were some twinges of regret such as one experiences in saying farewell to tried and true friends. "Public Health Nursing," "Institutional Nursing" and, quite recently, "Industrial Nursing" have carried special messages to nurses in those respective fields.

Fortunately, it is only the titles that have been changed — the flow of valuable material will continue under new page headings. Not infrequently, over the years, we have urged public health nurses to read an article on the pages deesignated for an institutional article and vice versa.

An excellent case in point is the article written by **Marion Wright** describing the study made at Harper Hospital, Detroit. Miss Wright had delivered this material in the form of an address to the Essex County Industrial Nurses' Association. They had forwarded it to the *Journal* so the first portion of it was published on their special page in the December issue. The balance of the article you will find under the new heading of **Nursing Service** where it logically belongs. Under this heading, too, will be found **Andrée Hébert's** valuable discussion of the havoc our modern dietary creates in promoting dental caries. That surely is of interest to all nurses — not just to those engaged in public health nursing. The very unusual situation that occurred in wha promised to be a straight forward delivery, as described by ***Winifred Anderson*** will provide a topic for discussion for many more nurses than those engaged specifically in obstetrical work.

* * *

Most of you have heard or read of the fact that the convention body last June unanimously endorsed the resolution to move our **National Office** to Ottawa. That move has already been effected. As you will note when you turn to the regular release prepared by National Office (which also is sporting a new heading) they have acquired ample accommodation in the new Excelsior Life Insurance Building at **270 Laurier Avenue, West, Ottawa.** Be sure to jot the address down somewhere so that you will have it for reference when you wish to write to Miss Stiver or one of the other secretaries.

Those of you who were at the convention will recall that when the question was raised as to whether or not the proposed move included *The Canadian Nurse,* your editor was emphatic that our two offices should be in the same city. Our expectation was, therefore, that the *Journal* offices would also be moved to Ottawa. In fact, that probability was expressed in this column. But, alas! We reckoned without consideration for the rental our space requirements would necessitate! So, regretfully, we have seen our colleagues at National Office move to Ottawa while the *Journal* has renewed its lease (for the same rent!) on the office space it has occupied for the past two years. Please come to see us when you are in Montreal. Our address is still **1522 Sherbrooke Street West, Montreal.**

* * *

Last month and again this month we have inserted the application form for your convenience in requesting a copy or copies of the 1954 index. Perhaps you have wondered why we do not just keep the list on hand of those who have written in for the Index in other years. Actually, we have that list but nurses change their addresses so frequently (we had 484 such changes during October, 1954!) we have found it a better plan to await your requests. Please write immediately while our supply is adequate. There is no charge for this Index.

* * *

Within the next few months the Cumulative Index for the past five years — 1950-54 — will be available for purchase. This Index is an invaluable reference book for libraries in schools of nursing, university schools, nursing association offices, and for personal use. Material from each of the 60 issues is indexed not only by author and article title but also under topical headings. As nearly as can be estimated the cost per copy of this book will be $2.50.

New Products

Edited by DEAN F. N. HUGHES

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

NITRETAMIN

Manufacturer—E. R. Squibb & Sons of Canada Ltd., Montreal.
Description—Triethanolamine trinitrate diphosphate 2 mg. tablets.
Indications—For prophylaxis of angina pectoris.
Administration—Usual dose is 4 to 5 tablets per day, one before each meal and 1 or 2 at bedtime. There may be no significant effect before the third day and the full effect may not develop in less than a week. Not recommended for treatment of acute attacks.

PHOLDINE

Manufacturer—British Drug Houses (Canada) Ltd., Toronto.
Description—Pleasantly flavored demulcent syrup containing Pholcodine (morpholinylethyl morphine) 1.0 mg. per ml., with potassium citrate, glycerin, and alcohol 10%.
Indications—Suppression of the cough reflex.
Administration—Children ½ to 1 teaspoonful up to 3 times daily. Adults: 1 to 2 teaspoonfuls up to 4 times daily.

SERFIN

Manufacturer—Parke, Davis & Company, Ltd., Walkerville, Ontario.
Description—A pure crystalline alkaloid of **Rauwolfia serpentina** having the hypotensive action and tranquilizing effect of the whole root of the plant.
Indications—The treatment of hypertension.

REAMIDE

Manufacturer—Webber Pharmaceuticals Ltd., Toronto.
Description—Each enteric coated tablet contains 0.75 gm. of especially refined Urea C.P.
Indications—In the management of patients who require safe diuresis in longstanding cardiac edema, chronic nephrosis and nephrotic type of glomerulonephritis.
Administration—Until diuresis is established 5-6 tablets every 2 hours. Maintenance dose is 3-4 tablets 4 times daily.

SALENESIN

Manufacturer—H. Powell Chemical Company Limited, Bowmanville, Ont.
Description—Compressed tablet containing: Salicylamide 130 mg., mephenesin 400 mg., secobarbital 5 mg., homatropine methylbromide 0.3 mg.
Indications—As an analgesic, antispasmodic and relaxant in muscle and joint pains.
Administration—1 to 3 tablets four times daily.

STRESSCAPS

Manufacturer—Lederle Laboratories Division, North American Cyanamid Limited, Montreal.
Description—Each capsule contains: Thiamine mononitrate (B_1) 10 mg., riboflavin (B_6) 10 mg., niacinamide 100 mg., ascorbic acid (C) 300 mg., pyridoxine HCl (B_6) 2 mg., vitamin B_{12} 4 micrograms as present in concentrated extractives from streptomyces fermentation, folic acid 1.5 mg., calcium pantothenate 20 mg., vitamin K 2 mg.
Indications—In conditions where physiologic stress has caused severe tissue depletion of ascorbic acid and of the B-complex vitamins. These include gastrointestinal disease, severe communicable disease, severe infection, and debility following operations, after sustaining fractures and other serious trauma.
Administration—*Adults*—1 capsule daily or as directed by the physician. **Precautions:** If dosage is kept within the limits indicated above, the possibility of undesirable reactions is negligible. Patients should not, however, be kept for long periods on high-potency vitamin therapy without medical supervision.

TELVOL

Manufacturer—Frank W. Horner Limited, Montreal.
Description—Brand of 2,2-diisopropyl-4-hydroxymethyl-1,3-dioxolane, Horner. Each emerald green enteric capsule contains: Telvol 250 mg.
Indications—For relieving the cramps, backache, spasm of dysmenorrhea.
Administration—One or two capsules after meals and at bedtime beginning 24 hours before the anticipated onset of symptoms. Continue as long as necessary.

ALUCOTE

Manufacturer—Bell-Craig Ltd., Toronto 2.

Description—An amphoteric colloidal aluminum hydroxide gel combined with Silicone, (polydimethylsiloxane).

Indications—Prophylaxis and treatment of duodenal and gastric ulcer and for gastric hyperacidity. Acts as a combined protective coating and antacid.

Administration—One or two teaspoonfuls ½ hour after meals, between meals and before going to bed, or as directed by a physician.

AMBENYL

Manufacturer—Parke, Davis & Company, Ltd., Walkerville, Ontario.

Description—A black-cherry flavored preparation of ambodryl hydrochloride, benadryl hydrochloride, ammonium chloride, potassium guaiacolsulfonate, dihydrocodeicone bitartrate, and menthol.

Indications—For relieving patients with coughs associated with colds, or coughs having an allergic origin.

BEROCCA-C 500

Manufacturer—Hoffman LaRoche Limited, Montreal.

Description—Duplex package, contains one 2 cc. ampoule of Berocca-C and one 2 cc. ampoule of vitamin C sodium injectable, 400 mg. When the contents of both ampoules are aspirated into the same syringe, the resulting solution will provide 5 B-complex factors plus 500 mg. of vitamin C for intravenous or intramuscular injection, or for convenient addition to parenteral infusion fluids.

Indications—Mild and severe deficiencies of water-soluble vitamins. Acute disorders requiring parenteral administration. Preoperative and postoperative treatment of surgical patients. Gastrointestinal disorders. Prolonged and wasting diseases.

Administration—May be added to parenteral infusion fluids such as amino acids, solutions of sugars, physiological saline, or electrolyte replacement fluids. A daily dose of 2 cc. or more may also be given by *slow* intravenous or intramuscular injection without dilution.

BRO-THEO

Manufacturer—Webber Pharmaceuticals Limited, Toronto.

Description—Each tablet contains: 50 mg. Pamabrom, (2-amino-2-methyl-1-propanol 8-bromotheophyllinate), 30 mg. pyrilamine maleate.

Indications—For premenstrual tension.

Administration—Two tablets twice daily (morning and night) beginning when symptoms are expected — usually 5 to 7 days before menstruation.

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Indications—In all conditions where a specific, powerful lipotropic treatment is indicated.

Administration—One tablespoonful three times daily as directed by the physician.

NARISYN

Manufacturer—H. Powell Chemical Company Limited, Bowmanville, Ont.

Description—An isotonic solution of phenylephrine hydrochloride 1%, a sympathomimetic amine related chemically to epinephrine unlike which, it is stable, more lasting in action, useful upon repeated administration and without significant stimulating influence upon the central nervous system.

Indications—In the symptomatic treatment of nasal congestion accompanying such disorders of the upper respiratory tract as sinusitis, vasomotor rhinitis and hay fever.

Administration—Instill 3 or 4 drops in each nostril every two hours.

Osteoarthritis may be aggravated by too little activity as well as by overactivity, stresses and strains. Aged osteoarthritic patients not infrequently were severely disabled by hospitalization with complete bed rest. — F. D. HART and others, *Brit. M.J. 2:269* July, 1954.

Older people need a balanced diet, without which they may suffer a mild form of malnutrition. If there are dental troubles, the meal grinder will help to break down tougher foods. Elderly people may find that four or five light meals are easier on their digestion than three heavier ones.

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A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 51 NUMBER 1

MONTREAL, JANUARY, 1955

On the March

This is the present the past built
Thought by thought — stone by stone.
We may pick the past apart
We may learn from the past
But we may not change it.
Ahead is the future the present will build;
Each thought that is thought today,
Each stone that is laid today,
Whatever the past has taught us,
Whatever the present discloses,
All these combine to form tomorrow's pattern.[1]

The foregoing indicates that just as our present resulted from the past so our future is determined by the present.

In an effort to fully appreciate the significance of those events of the past which have affected the present, let us take a backward glance at what our predecessors agreed was the purpose of the Association then known as the Canadian Society of Superintendents of Training Schools for Nurses.

The object of this Association shall be to consider all questions relating to nursing education; to define and maintain in schools of nursing throughout the country minimum standards for ad-

Ashley & Crippen, Toronto

GLADYS J. SHARPE

(1) New York Herald Tribune—October 25, 1953.

mission and graduation; to assist in furthering all matters pertaining to public good by cooperation with other education bodies, philanthropic and social; to promote by meetings, papers and discussions cordial professional relations and fellowship; and in all ways to develop and maintain the highest ideals of the nursing profession.[2]

In September 1907, forty-three representative nurses from seven provinces, constituting the charter members of the first Canadian National Association of Trained Nurses, met in Montreal and adopted the foregoing as the "object" of their constitution. Forty-seven years later another climactic event in Canadian nursing history was enacted at the biennial meeting in Banff when more than 1,200 members adopted the recommendations of a four-year study of the objectives, functions, machinery and relationships of the association as a whole. The first step to implement the recommendations was the appointment of the chairmen of the five National Committees by the Executive Committee on the day following the conclusion of the general meeting.

The spirit of our "founding fathers" must have been present at the first executive and sub-executive meetings of this biennium. The atmosphere seemed to be charged with a singular awareness that if, in keeping with the philosophy of our association, the cumulative views of individual members is to be reflected in unified effort and if these views are to be sound, they in turn must be the consequence of widely diffused knowledge. The principal task of this biennium would appear to be one of harmonizing provincial interests and efforts with national interests and responsibilities. While the wording of the objectives of the past has been altered and our machinery brought in line with today's needs, the philosophy is unchanged. The youth of today has been adjured to "Go forth in the spirit of the founding fathers but not in their steps." So in the spirit of the past we set tomorrow's pattern today — may it be one which will place the future in our debt.

WE ARE ON THE MARCH

GLADYS J. SHARPE
President
Canadian Nurses' Association

(2) Proceedings of the First Annual Convention of the Canadian Society of Superintendents of Training Schools for Nurses.

Notice to Industrial Nurses

The Bilingual Division of Industrial Nurses of the Province of Quebec will hold an Institute on February 25 and 26, 1955, at the Chateau Frontenac in Quebec City.

The industrial nurses of Quebec City and surrounding area will be your hostesses at this time and are planning an interesting and educational program.

A dinner meeting will be included on the evening of February 25, which will provide an opportunity to meet new friends in an informal social atmosphere. We are certain you will wish to keep these dates in mind and plan to enjoy this trip to historic Quebec.

Details will be provided nearer the time of the Institue.

Avis aux Infirmières industrielles

La division bilingue des infirmières industrielles de la Province de Québec tiendra un congrès les 25 et 26 février au Château Frontenac à Québec.

Les infirmières d'industrie de la ville de Québec et des environs seront vos hôtesses dans la circonstance et préparent un programme qui sera à la fois agréable et instructif.

Un banquet marquera cette réunion et aura lieu dans la soirée du 25 février; ce dîner fournira à toutes l'occasion de camaraderie. Nous sommes assurées que vous vous souviendrez de ces dates et que vous vous organiserez de façon à profiter de ce voyage dans cette ville historique.

De plus amples détails vous seront donnés à l'approche de la date de ce congrès.

Some Problems of the Aged in Medical Practice

G. A. Copping, M.D.C.M., M.R.C.P. (Lond), F.R.C.P. (C)

One of the most interesting developments of the 20th century has been the lengthening of life span in those countries enjoying the benefits of western civilization. The peoples of some of the less advanced parts of the world live for an average of 22 years, a life expectation enjoyed by the citizens of Rome in the days of the Caesars, whereas modern western man looks forward to more than 60 years of life. This has been a tremendous advance which has been made possible by science's contributions to the foods we eat, the purity of the water we drink, the diseases we have stamped out or controlled, the better houses we live in, our better clothing, our present safer surgery, and most recently, the antibiotic drugs. People who formerly died in childhood of diphtheria or scarlet fever or in young adult life of pneumonia or tuberculosis now either avoid these diseases altogether or live through them to become that part of the population now in its fifties, sixties or seventies.

There are more old people in Canada today than there have ever been before. In the admissions to one of the large general hospitals in Montreal the number of patients over 65 years of age has doubled in the past 25 years. This is but a reflection of what is going on in the general population and there are indications that the rise will continue. The trend is not a new one. Early findings suggest that man of the bronze era lived to an average age of 18 years; by the beginning of the Christian era his average expectation of life was 22; in the Middle Ages it was 35 and at the turn of this century it was 49 years. Today in the most socially advanced parts of Canada the improvement in our standard of living and in particular the reduction in infant mortality has blessed us with a life expectation of 70 years. If we were to conquer cancer and the degenerative diseases of arteries, there is no telling how high the final figure might rise.

What does this increase in the number of old people in Canada mean to the doctors? Are the diseases of old people different from those of the more youthful? Do older people require different treatments? Do drugs have the same effect upon them? Can they be operated upon as safely? One can answer these questions best when one understands the two principal changes that occur with aging.

As one grows older one loses *blood supply* and *motivation*. The first of these factors results from the closing down of very small blood vessels all over the body. This slow process, the result of hardening of the arteries or arteriosclerosis, gradually deprives the tissues of blood and, in consequence, they waste. The aging person shrinks — he becomes shorter and often thinner. All his internal organs take part in the process. It follows that there is not as much heart muscle or lung tissue as there was and old people are, therefore, short of breath on exertion. There is not as much intestinal muscle or as many glands to secrete the digestive juices and so old people must avoid large meals, especially heavy, rich, fatty ones. The brain shrinks and old people fatigue mentally. Noise and commotion upset them. Their memory, especially for recent events, lessens. There are certain drugs, notably the strong sedatives and the anesthetics, that act in a manner similar to shutting off the tissues' blood supply. These drugs, while they are quite safe if used carefully, must be given with more than usual caution to the elderly. Old people, in short, do require special attention in their medical management.

Dr. Copping is assistant professor of medicine, McGill University, Montreal.

Old people lose motivation. The body is not an automatic machine which runs simply by setting it going. It has to have over it, constantly, a driving, directing force. In some people this is ambition, the competitive instinct, the desire for money, position, the approval or the respect of friends or fellow workers. In some it is fear, in some greed, in others a decent sense of responsibility. We all have to have something to keep us at the day's work, either a whip upon our hindquarters or a carrot dangling in front of our noses! Old people, in the nature of things, lose the motives that kept them striving when they were younger. They can no longer compete physically as they did and younger men get their jobs. Their friends are no longer there to cheer or encourage them. Their families have grown up and have ceased to be the responsibility that once kept them busy.

When organic disease strikes an old person it often seems to remove what little was left to him of his former motives. "What use am I," says the hemiplegic, "with one side of me paralyzed? How can I keep a job? How can I get about and do the things I used to do? Why continue to struggle? Why not give up?" They often do give up and one sees the elderly sick sink down through the apathy of discouragement to the bed-ridden state, bed sores and terminal pneumonia. Recovery might have been possible and the patient might have been rehabilitated to a life of reasonable usefulness if he had only felt it to be worthwhile.

What can doctors and nurses do about this problem of the loss of an old person's motivation? We cannot give him new blood vessels, but can he be helped in his motivation? The principal need is one of prevention. When people are still young enough to pick up new ideas they should be encouraged to develop hobbies and outside interests for one's family and job are not enough. Interest in the world about them, hobbies that can be a source of pleasure on into old age are the answer. If all else is lost there still will be these to be lived for. What of the elderly person who, having fallen sick, has not had the advantage of this farsighted preparation? Can he be helped? Can he be encouraged back to the desire to keep going?

A recent case might be cited. An elderly man with high blood pressure had been condemned to a life of invalidism. He lay waiting, fearfully, for the end. He knew there was nothing for him in life — he had been told so. Taking courage in their hands, one member of the family and the doctor got him out of bed and to a part-time job, something to do, something to get up for each day! He now had a motive and while he lived no longer because of it, at least he was happy. Surely one's last days are better that way!

It is an uphill battle but with patience, imagination and a family that earnestly wants to help, very often much can be done. It is amazing how well the oldsters usually do if they are given hope and a sense of being needed and wanted. There is no tonic for old people like the knowledge that life still holds something for them.

The oral changes in nicotinic acid deficiency present most striking clinical manifestations and most painful symptoms. The gingivae, cheeks, lips, and tongue are fiery red in color, associated usually with acute pain. The tongue may present varied pathologic changes, depending on the duration and severity of the deficiency. In mild deficiency states, the dorsum of the tongue may have a bright red, granular appearance; or in more severe forms of pellagra, there may be complete atrophy of the papillary coating. Painful superficial ulcerations of this organ are common, especially along the lateral margins of the tongue where it comes in contact with the teeth.

Ulceronecrotic gingivostomatitis, or Vincent's disease, may be present, secondary to nicotinic acid deficiency. This condition will not respond satisfactorily to the usual local therapeutic measures until the nutritional deficiency is corrected. While dermal lesions may co-exist in nicotinic acid deficiency, it is not uncommon to find the acute clinical manifestations of this deficiency limited to the oral tissues.

—L. W. Burket, in *The Merck Report*, Oct., 1954.

Les Problèmes Posés par l'Augmentation de la Longévité

J. Sebaoun

Les progres de la médecine, une meilleure organisation de l'hygiène publique ont abouti à une brusque et considérable augmentation de la longévité. La durée moyenne de la vie s'était élevée lentement des environs de 35 ans au Moyen Age jusqu'à 48 ans en 1900. En un demi-siècle elle a dépassé 65 ans. Encore faut-il comprendre dans ce chiffre la non négligeable mortalité infantile, et les statisticiens ont établi qu'un individu aujourd'hui âgé de 40 ans peut espérer atteindre 70 ans si c'est un homme et 75 ans s'il appartient au sexe féminin.

C'est là un résultat qui paraît magnifique, et le premier des voeux formulés à chaque anniversaire: "longue vie", est réalisé. Mais on y ajoute habituellement "santé et bonheur". Compléter la triade, tel est le but qu'on peut fixer à la gérontologie.

Qu'est-ce donc que la Gerontologie?

Cette discipline nouvelle a pour objet l'étude du vieillissement, de ses causes, de ses conséquences, des remèdes qu'on peut y apporter. C'est dire qu'elle déborde largement le cadre de la médecine et de la biologie. Des impératifs économiques l'orientent de plus en plus sur un plan social.

Augmentation de la longévité a en effet pour corollaire augmentation de l'âge moyen de la population. Cette dernière est particulièrement flagrante dans notre pays à natalité longtemps basse et qui ne profite que très peu des avantages démographiques de l'immigration. Les conséquences de ce vieillissement sont dramatiques. D'abord accueilli avec une curiosité attendrie et fêté dans ses précurseurs — le dernier survivant de Reichoffen, les centenaires décorés, la doyenne des Français — le flot des vieillards est maintenant contemplé avec consternation. Il vient en effet accroître les charges sociales; les vieux doivent être entretenus, par leur famille et plus souvent par la collectivité. C'était facile au début du siècle où il y avait vingt travailleurs pour subvenir aux besoins de trois vieillards, c'est plus difficile aujourd'hui où ils ne sont plus que dix pour remplir ce rôle, ce sera impossible demain lorsque, comme on peut le prévoir à 20 ans d'échéance, il y aura en 1970 un vieillard pour trois adultes.

Toutes ces notions sont maintenant bien connues, beaucoup mieux que leur cause, le vieillissement. La société s'est en effet construite autour de l'adulte et pour lui. Elle s'est ensuite intéressée à l'enfance et a créé la puériculture et la pédiatrie. A notre époque et dans notre pays, la mortalité infantile qui sévit dans les contrées arriérées, et les habitudes spartiates de suppression des enfants malingres ou anormaux paraissent monstrueuses. Et pourtant c'est presque ce que nous faisons de nos vieillards. Il nous faut maintenant nous occuper d'eux et en premier les définir.

D'emblée on se heurte à une première difficulté, qu'est-ce qu'un vieillard? Les seules définitions que nous en connaissions sont d'ordre social, le vieillard est un infirme ou un invalide. Il ne travaille plus parce qu'il est malade ou qu'il a atteint l'âge de la retraite. La vieillesse a donc jusqu'à présent été définie par des ordonnances gouvernementales, et elle est fondée sur la notion arbitraire d'âge chronologique. Il faut que le biologiste y substitue la notion d'âge réel.

L'étude du vieillissement va buter sur un premier obstacle, à savoir les rôles respectifs de la maladie et du processus normal de sénescence dans la sénilité.

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La maladie est en effet fréquente chez les vieillards. L'âge entraîne une recrudescence des affections chroniques. Au premier plan sont les troubles circulatoires (hypertension artérielle, artériosclérose avec ses conséquences cardiaques, cérébrales et rénales), et les affections ostéo-articulaires. Leur fréquence est si grande qu'on a voulu y voir la cause même de la vieillesse et qu'on a créé des théories endocriniennes ou fondées sur l'artériosclérose du vieillissement. En fait les maladies chroniques ne font que favoriser le processus de sénescence. Elles ne sont pas le privilège du vieillard. On les rencontre à l'âge adulte et même chez les sujets jeunes. Elles ne sont pas inéluctables, leurs habitudes alimentaires permettent en effet à certains peuples d'échapper à l'artériosclérose; c'est le cas des habitants de la Chine du Nord, ils n'en vieillissent pas moins que le reste de l'humanité.

L'étude de ces maladies n'est donc pas le but principal de la gérontologie. Leur prévention et leur traitement sont de passionnants et difficiles problèmes de pathologie générale.

Cependant toutes les maladies du vieillard ne ressortissent pas à l'artériosclérose ou au rhumatisme, sur un tel terrain toutes les affections évoluent d'une façon torpide et sous des apparences trompeuses. Derrière une insuffisance cardiaque peut évoluer une maladie infectieuse facilement curable par les antibiotiques, un hématome sous-dural peut stimuler le ramollissement cérébral, il est pourtant du ressort de la neuro-chirurgie. Le vieillard, par ailleurs, se défend mal contre les agressions, il faut associer chez lui aux traitements spécifiques un traitement général. La nécessité qu'il y a à lui apporter de l'eau, des sels minéraux, des vitamines et certaines hormones est bien connue. On pourrait presque dire trop connue. Les traitements perfectionnés permettent maintenant de maintenir en survie prolongée des êtres qui n'ont plus rien d'humain et qui ne profitent vraiment plus du sursis qu'on leur procure. Nous connaissons tous dans les services hospitaliers des cancéreux, des pseudo-bulbaires, des gâteux auxquels la pneumonie, l'érysipèle ou l'infection urinaire auraient autrefois apporté un prompt soulagement de leurs souffrances. La thérapeutique ne fait que prolonger leur calvaire et celui de leurs familles, tout en coûtant fort cher à la société. Ces faits sont suffisamment graves pour avoir provoqué une communication au Congrès de Gérontologie de Liége. En rapportant l'histoire d'une femme de 70 ans qui après plusieurs attaques était complètement paralysée et inconsciente, et que les antibiotiques ou les anticoagulants avaient permis à plusieurs reprises de guérir d'infections pulmonaires et de phlébites, Roskam demande si dans de tels cas le médecin ne doit pas borner son rôle à faciliter les derniers instants et à pratiquer aussi une véritable euthanasie par omission. des soins. La gériatrie pose donc aussi des problèmes moraux dont on voit la gravité.

Mais à côté des vieillards malades il y a des vieillards bien portants, c'est chez eux qu'on peut apprécier les troubles propres au vieillissement. Ce dernier entraîne une dévaluation générale de l'individu, conséquence d'une activité insuffisante de ses organes. A son terme il existe un trouble global de la nutrition. L'apport des substances nécessaires à la vie, leur répartition dans l'organisme, leur utilisation par les tissus, l'évacuation des déchets sont également compromis. Chacune de ces défaillances retentit sur les autres réalisant une sorte de cercle vicieux. Mais on ignore comment l'organisme entre dans ce cercle. Les théories les plus répandues invoquent un obstacle entre les parenchymes (les tissus des organes actifs de l'économie, les viscères, les muscles, les glandes) et le milieu nutritif. Lorsqu'on faisait jouer un rôle important à l'artériosclérose, on plaçait l'obstacle sur les parois vasculaires, on le place maintenant au niveau du tissu conjonctif qui forme la matrice et l'armature des parenchymes. Ces théories se fondent sur des notions expérimentales: convenablement repiquées sur des milieux neufs, les cultures d'organismes unicellulaires où chaque élément baigne largement dans le milieu ambiant peuvent être maintenues en vie presque indéfiniment. Les cultu-

res de petits fragments d'organes nécessitent encore plus de soin pour bénéficier d'une survie très prolongée. Par contre les organismes pluri-cellulaires sont tous voués à la mort.

La déficience des différents parenchymes est difficile à étudier directement. Il est plus aisé d'en mesurer les conséquences. On pourra ainsi soit faire une étude globale des différentes capacités, physique, intellectuelle, de reproduction, à des âges différents, et préciser ainsi la valeur intrinsèque de l'individu; soit encore étudier les différents appareils, circulatoire, digestif, respiratoire, endocrinien, et définir ainsi une valeur médicale du sujet et pouvoir pallier certaines anomalies; soit enfin déterminer le taux des constantes biologiques, formule sanguine, protides, sucre, lipides, métabolisme de base, épreuves d'un très grand intérêt physiologique parce qu'elles sont les plus à même de préciser le mécanisme du vieillissement.

Ces différences techniques se complètent, peuvent donner plusieurs aspects d'un même trouble et parfois permettre d'en saisir la cause. Ainsi une diminution de la capacité physique, accompagnée de troubles cardiaques et respiratoires peut être due à une anémie, elle-même conséquence d'une mauvaise dentition et des troubles digestifs qui l'accompagnent.

Cette étude du vieillard est à peine commencée, ses résultats sont encore fragmentaires. Mais elle met en évidence la variation de vitesse du processus de sénescence d'un individu à l'autre, le rôle que joue le mode de vie, l'état pathologique antérieur. Elle permet aussi de saisir l'irrégularité de sa répartition chez un même individu. Elle montre enfin que le bilan de la sénescence n'est pas complètement négatif et que la vieillesse apporte des qualités nouvelles et utilisables.

Certes le bilan des capacités physiques est habituellement désastreux, et assez précocement, puisque la force et la résistance physique diminuent dès la quarantaine. Mais les fonctions intellectuelles ne sont atteintes que plus tardivement et assez lentement.

Un certain nombre de tests psychologiques et psychotechniques ont montré une remarquable conservation de l'habileté manuelle, surtout chez les gens habitués à travailler de leurs mains et plus particulièrement chez les femmes. Ce n'est qu'après 70 ans que cette habileté manuelle diminue brusquement. Et pourtant l'âge diminue la rapidité des réflexes. C'est qu'il s'accompagne de nouvelles qualités que nous appellons expérience, jugement et adresse faute de pouvoir les mesurer.

L'intelligence ne décroit que lentement avec l'âge, la faculté d'apprendre et de comprendre n'est pratiquement pas touchée, à condition d'avoir été entretenue pendant toute la vie, mais l'intérêt porté aux choses se restreint et s'oriente; la vieillesse est l'âge de l'utilisation des connaissances plus que de la création.

Le vieillard n'est donc pas un inutile. Le fait est évident quand on sort du prolétariat industriel, et tant dans les professions libérales que dans l'artisanat, l'âge ne constitue pas, loin de là, un handicap. L'utilisation d'une main-d'oeuvre industrielle sénile pose d'autres problèmes. Le vieillard y est mis à la retraite pour deux sortes de raison, les unes sentimentales les autres économiques. On peut penser qu'après avoir durement travaillé pendant une quarantaine d'années, avoir ainsi contribué à la prospérité de son pays, souvent l'avoir défendu, avoir fondé et entretenu une famille, l'homme a le droit de se reposer et de demander à la société aide et assistance. Par ailleurs la présence d'un vieux travailleur, moins rapide et moins actif, diminue le rendement et augmente ainsi le prix de revient; on ne saurait imaginer sous les traits d'un vieillard l'ouvrier de choc, stakhanoviste ou tayloriste parfait. La retraite apparaît comme une solution logique et équitable qui permet au vieil ouvrier choyé par ses cadets et profitant de la prospérité générale d'attendre une mort sereine.

En fait les buts recherchés ne sont pas atteints. Economiquement les conséquences de la retraite sont catastrophiques. C'est seulement en apparence que l'écartement des vieux travailleurs diminue le prix de revient. Le salaire de son successeur doit en réalité être majoré du montant si minime soit-il

de l'allocation de retraite. D'autre part l'absence du vieillard diminue la masse totale de main-d'oeuvre, ce qu'on pourrait appeler le potentiel de production du pays, sans diminuer d'autant la consommation. La part qui revient à chacun en est amoindrie. Ainsi parce qu'il faut lui donner une retraite, parce qu'il ne travaille plus, et qu'il continue à consommer, le vieillard, invalide obligatoire, est triplement à charge.

Le seul moyen qu'on ait de lutter contre un péril économique imminent est d'utiliser la main-d'oeuvre sénile. L'expérience a été tentée aux USA pendant la guerre. En 1942, Wharton a pu constituer des ateliers de vieux ouvriers aux usines Dodge. Les possibilités d'individus handicapés par l'âge et la maladie purent y être utilisées pour le plus grand avantage de l'entreprise et des employés. Un même effort a été tenté par Ford dans ses usines de Rivière-Rouge. En 1943 plus de 27% de ses ouvriers avaient dépassé 50 ans, plusieurs centaines avaient plus de 70 ans, et sept travailleurs étaient des octogénaires. Le fait est d'autant plus intéressant que le chiffre de 27% de plus de 50 ans représente presque, compte tenu du nombre des enfants et des adolescents non encore aptes à travailler, la fraction de la population américaine ayant atteint ou dépassé cet âge. Ainsi a pu se réaliser sous l'impulsion des nécessités de la mobilisation industrielle une expérience de plein-emploi. Elle n'a été possible que grâce à une expertise exacte des possibilités de chaque employé et une étude complète de chaque poste. C'est dans ce sens que doivent s'orienter nos efforts. La psychotechnique et ses tests, jusqu'à présent utilisée pour orienter la main-d'oeuvre juvénile doit tout au long de sa vie mesurer la valeur professionnelle de chaque ouvrier. On pourra empêcher ainsi l'apparition d'un fossé qui va en s'élargissant entre le travail qui ne change pas et l'homme qui se modifie sans cesse. Une telle mesure pourrait d'ailleurs avoir un intérêt médical: en écartant le travailleur d'une activité qui ne répond plus à ses capacités, à ses ambitions et à l'intérêt qu'il y porte, on éviterait des accidents du travail, des névroses professionnelles et ces agressions psychiques répétées qui hâtent peut-être la sénescence.

Sur le plan sentimental, l'échec de la retraite est tout aussi grand. Elle constitue une sorte de mise au ban de la société. Le retraité doit affronter une nouvelle vie qui n'a pas été préparée. Toutes ses habitudes sont modifiées. Il n'est pas heureux et souffre d'autant plus que le montant de son allocation est en général minime. Cet état altère sa santé par un mécanisme que la médecine psycho-somatique permet de comprendre, et la retraite transforme souvent en invalide un vieillard jusque là bien portant. Elle augmente encore la charge imposée à la société.

Pour être véritablement la récompense des mérites passés, la retraite doit être préparée. La vie qu'on lui propose doit être à la mesure du vieillard, elle doit lui apporter l'hygiène physique et l'hygiène mentale.

La première est relativement simple à réaliser. Le vieillard a besoin d'exercice proportionné à ses possibilités, il faut le lui enseigner pour qu'il le prenne avec goût. Un entraînement antérieur peut permettre jusqu'à un âge avancé la pratique des sports, ce n'est un privilège royal que dans la mesure où la royauté facilite l'usage des sports d'agrément. L'alimentation du vieillard doit subvenir à ses besoins, sa valeur énergétique peut donc être réduite, mais elle doit apporter des matériaux de construction, des protides, et être enrichie en sels minéraux et en vitamines (A et complexe B). L'alcool et le tabac ne sont pas contre-indiqués. L'absorption et la digestion des aliments doivent être facilitées aussi faudra-t-il veiller à leur préparation et à leur présentation tout autant qu'au maintient en bon état des dents et du tube digestif. Le vieillard dort souvent mal, une literie de bonne qualité, des vêtements de nuit confortables, une bouteille d'eau aux pieds, une boisson chaude au moment du coucher y palient souvent mieux que les somnifères.

L'hygiène mentale pose d'autres problèmes, elle doit fournir une occupation agréable et lutter contre l'ennui. La vieille femme, toujours capable de s'employer aux besognes domestiques,

l'agriculteur qui trouve toujours à la ferme une tâche à sa mesure sont plus avantagés que l'homme de la ville. Il faut savoir utiliser ses marottes, encourager chez lui un goût pour la lecture, les arts d'agrément, le bricolage.

Ces solutions peuvent être grandement facilitées par la vie en commun dans des maisons de retraite que les vieillards habiteraient ou viendraient simplement fréquenter. Créées dans le cadre d'une entreprise elles permettraient au vieillard de ne pas être coupé de sa vie antérieure et le libérerait de l'appréhension d'entrer dans un monde inconnu. Sous la surveillance d'infirmières et d'assistantes sociales spécialisées, c'est-à-dire pleines de sympathie et de bienveillance, ils pourraient assurer en grande partie la marche de l'établissement.

Voilà quels sont, évoqués de façon incomplète et simpliste, les problèmes auxquels s'attaque la Gérontologie. C'est au fond l'aboutissement de toutes les branches où elle se développe. Médecine, Biologie, Economie, Sociologie, puisque c'est à elle que s'applique le mieux l'aphorisme de Piersol et Botz: "La science n'a pas seulement pour but d'ajouter des années à la vie, mais surtout de la vie aux années." On pourrait ajouter "et du bonheur."

The Aged in Hospital

SISTER MARY FRANCIS

LACK OF HOUSING accommodation and inadequacy of living arrangements for older persons who are ailing have placed greater demands upon already limited hospital facilities. Many are occupying beds that are urgently needed for more acutely ill patients requiring medical and nursing care. To a certain degree, the relief experienced by transferring the responsibility of aged relatives to hospital is an inducement to leave them there as long as the hospital will accept the responsibility. This is due to several factors: To the increasing number of childless couples; to the trend to smaller families and homes; and to social attitudes unfavorable to the continuation of the multi-family home. There is a real necessity for some other type of facilities since the home environment among the aged is usually unsuitable either for bed care or convalescence. Because of this they are more frequently admitted to hospital. If proper accommodation were available for the chronically ill and ambulant cases, the overcrowding of hospitals would be eased and some of the urgent problems, such as, lack of companionship, proper nutrition, suitable recreational facilities and a counselling service would be solved.

Life expectancy in Canada has increased for both men and women. A child born today can expect to live at least 18 years longer than his grandparents. Prompt detection and treatment of degenerative diseases in middle aged and elderly people can make this 18 years a period of vigorous living, not just survival. Surveys have shown that those who have periodic health examinations live longer, on the whole, than those who do not.

Most doctors realize that the aged are capable of many kinds of work and that those who keep busy are more vigorous and useful than those who are idle. Tests made on this age group prove that many people over 65 can think as well if not better than young folk although they may act more slowly. It has been said that a 60-year-old man may have a 40-year-old heart, 50-year-old kidneys and an 80-year-old liver, yet he may try to live as if he were 30!

The increase of hospital accommodation has been greatly encouraged by the construction grants of the National

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Health Program but the number of beds still falls short of the facilities needed. Geriatric units and provision for these patients at larger general hospitals has been a matter of some interest. In England, the British Medical Association has sponsored a plan which includes the provision of a geriatric department in the hospital with long-stay annexes and residential homes for those not in need of regular medical or nursing care.

Research is being carried on to determine the biochemical changes in older persons and their problems of social adjustment. Counselling service is also provided to deal with emotional problems of those old people who otherwise might become inmates of mental hospitals. Another study of interest concerns the nutritional requirements of the older age group. Mental illness in the age group, 70 years and over, is a serious problem today. They form the majority of those admitted to mental hospitals for the first time and comprise one-third of the number of patients in those hospitals.

The admission of sick aged to hospital needs to be arranged more scientifically as a partnership between the hospital and the health department with greater cooperation from the family. Except in the case of acute illness when immediate admission is necessary, a study should be made to determine the need for hospital care and to establish the obligation of relatives.

Special Aspects of the Nursing Care of the Aged

KEES KORT, M.D.

SINCE PEOPLE NOW LIVE LONGER, due in part to advances in medicine, the care of the aged becomes, in its own right, a nursing problem requiring more and more attention. More people are spending the latter years of their lives under psychiatric treatment and it is therefore of prime importance that the nurses who are responsible for their care know the physical and mental changes that occur in patients of this type. Ignorance and carelessness in the nursing of these old folk may result in rapid and severe deterioration.

Getting old is a progressive, degenerative process of all our organs in which both body and mind become increasingly rigid. The aged patient's resistance is decreased by this increasing rigidity to a point where a very small stress can cause damaging results.

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The keynote of nursing the aged is centred around "people, who for the most part, are unable for many reasons *to verbalize* their complaints" forcing the nurse to use observation as a tool in aiding them. It is much harder to nurse such a patient than one who is able to direct the nurse in her nursing care. Each nurse must learn to use certain general rules which apply to observing and recording patients' behavior.

If these general principles are applied the custodial care of a patient, which is often an automatic and almost meaningless routine, becomes consciously directed by the addition of a responsible interest in everything which the nurse does for the patient. This is "nursing."

OBSERVATION ADDED TO SOAP AND WATER TECHNIQUE

How often do you start your nursing care in the morning without "observation" so that the "care" begins with applying the soap and water you have

brought to the patient's side? For instance have you:

1. Made some effort at finding out how the patient slept, how she feels, and compared this with the previous morning? Have you checked how often the patient had to urinate during the night (nocturia is important in cardiac patients)?

2. Have you observed how the patient is lying in bed? Is she paying any attention to her surroundings? Did she look at you when you approached her bed?

3. Did you look at her eyes to see if they were sunken, bright or dull?

4. Did you ask the patient to show you her tongue to see if it was moist and red, or coated, furry and dry? Oral hygiene is extremely important — keep the mouth clean!

How many of these things did you do before you touched the patient? If you have not done them what do you mean when a doctor asks you of the patient's morning condition and you say, "The same, no better or worse." Your observation does not end here. There are many observations that can be carried out during the bathing period. Check:

Discoloration and temperature of fingers and toes.

Swelling around the ankles.

Redness of early bed sores.

Sacral edema and pitting due to wrinkles.

Breathing pattern and color of lips.

Check the temperature and humidity of the skin, before washing the arms. Notice whether your patient is tense or comfortable and relaxed, whether she is weak or listless. Aged people do not perspire as much as younger adults. Profuse perspiration in the aged is for this reason a warning sign. While completing the bed bath you are able to compare mentally the patient's condition to the previous morning. Body temperature, skin condition and appearance of the eyes are of great diagnostic importance to the doctor, who knows these signs, and knows, too, what they mean in the aged.

The Eating Tray

The next consideration in the nursing care of the aged is the eating tray. The food and fluid on the tray are meant in all instances for the patient's stomach and not the disposal unit. Elderly patients need a high protein diet and more vitamins than adults, especially B complex and vitamin C. Proper protein nutrition is necessary to build up their natural resistance and to protect them against infections. The vitamins play an important part in proper carbohydrate metabolism which is important for the normal function of the brain. Food intake for a bed patient must be approximately 2,000 calories daily. When he is up and moving about more calories are necessary. It is wise to note the approximate daily intake of calories on the chart so that if a patient is not getting enough calories from his regular meals, it can be given in some other way. The average daily fluid intake should be about 1,500 cc. How often did you attempt to find out why your aged patient would not take his meals? How often have you suggested to your supervisor that an egg-nog or a high protein drink would perhaps be taken by the patient and might be of benefit?

Urinary and Bowel Care

Bowel movements should be regular and any suspicion of constipation should be dealt with promptly. If bowel evacuation is neglected for some time or there is an insufficient movement, feces may impact. This condition may give signs of intestinal obstruction and this is playing with life. Can it be laid to poor observations in nursing care?

Check the approximate volume and color of urine. In men urinary obstruction due to prostate enlargement may cause incontinence as does uterine prolapse in females. This may end in renal failure and death.

Ward Behavior

Another important aspect in caring for and observing the aged is how the patient behaves on the ward during the day. The behavior in elderly people tends to be stereotyped. Any marked deviation must be noted as a behavior change since it very often heralds a physical illness.

Unless seriously ill these patients

should not lie in bed all day nor should they sit on a chair hour after hour without moving. Remember, an aged bed patient is an easy candidate for bedsores (especially if there is incontinence) and also for hypostatic pneumonia and thrombosis. The aged need exercise appropriate both in type and duration. If the body is to work properly it needs oxygen and in old folks the intake of oxygen, like everything else, is slower. Suitable exercise will enable the oxidative process to function at its maximum level. Encourage your aged patient in mental and physical activity.

Be very careful of both underactive and overactive patients especially when their behavior is different from day to day. Poor nursing often causes this change in behavior. An old person may be upset by not having a proper bowel movement or by having too little to drink.

Dehydration

Many aged people come to hospital in a dehydrated condition which upon inspection, is not due to infection, hyperactivity, profuse diarrhea, hyperglycemia or excessive vomiting, but simply due to the patient not having been given enough to drink. Thus, fluid intake must be stressed in the nursing care of the aged. The chart should record both the calorie and fluid intake of each patient daily.

Dehydration in the aged produces peculiar changes in the personality including irritability, quarrelsomeness, hyperactivity, dullness, confusion and hallucinations. Oddly enough the reverse action often occurs — overactivity, restlessness or any infection however slight may start the process of dehydration. Luckily this is often a reversible process. It is very important that the physician should be able to tell whether the dehydration precipitated the change in the patient or whether it is the result of some other condition. When the nurse observes any of these signs and symptoms she should record them and report immediately to the doctor. He may want to act on her information speedily. In some instances where fluids and electrolytes are lost as in diarrhea, vomiting, diabetic acidosis, Addison's disease, etc., it may be very dangerous to take fluids by mouth. The doctor must, after careful examination, decide what sort of fluid should be given and by what route. It is not enough just to give fluid — it must be the right fluid given in the right way. At the present time we are investigating the fluid balance in aged people. From our preliminary observations it looks as if many of the changes in behavior which usually need sedatives can be controlled just as well by giving enough of the right sort of fluid to dried-up old people.

Kindly interest often will help to prevent and control dehydration in elderly patients. Remember, frequently *you* must do the asking, thinking and acting for them. If they do not ask for fluids, then you must ask them. The greatest risk of dehydration is in helpless, confused, delusional, listless, uncooperative patients and in apparently healthy persons who suddenly develop an infection, become bed-ridden and difficult to manage. Signs and symptoms that may be due to dehydration:

Absence of moisture in axillae and groin.

Rapidly occuring personality changes — hyperactive, underactive, dull.

Loss of appetite, nausea, later severe vomiting.

Decreased urine output, change in color and concentration.

Changes in breathing pattern.

Changes in body temperature.

Blood pressure tends to fall with a slight increase in pulse rate.

Muscular weakness.

Thirst, dry tongue and mouth.

Summary

As people now live longer, nursing care of the aged becomes both more important and more urgent. Nurses are required to be more observant as many of the aged cannot convey their needs. Basic principles underlying good nursing care centre around proper diet and careful observation.

Housing Problems of the Aged

SISTER MARY MACKENZIE

IT WAS WRITTEN IN 78 B.C. that "you must begin to be an old man early, if you wish to be an old man long." In Mexico every boy is taught two hobbies, one for his years of strength and one for his years of weakness.

If children were trained gradually to assume responsibility and to develop imaginative thinking, no special programs would be needed when they in turn become senior citizens. This kind of education is sadly lacking today for various reasons. Grand-parents are a very helpful adjunct to the well-rounded upbringing of children. Instead we find the older folk feel unwanted and left out; the younger group feel hampered by their seniors. This attitude may be blamed partly on the discrimination shown in industry where the older worker is made to feel that he is not capable and must give place to the younger man. Thus, instead of fostering close association in family groups, we are forming strange lines of demarcation.

The problem of where our senior citizens should live is a very important one. Oldsters spend more time in their own quarters than do other age groups. It has been revealed that the worst housed segment of our population is this same age group. We find them living in houses, apartments or rooms constructed primarily for younger people. They may be rattling around in homes built during a period when they were raising a family. They may be crowded in quarters where steps and stairs take a toll of their hearts, squeezed in with their married children, with no place of their own to entertain friends. Some are in back flats in slums, in cubby holes in rooming houses and in institutional Homes for the Aged where, perforce, husband and wife are separated.

The psychological desire to be wanted, to be useful, for love and companionship, for creative expression as well as economic security is just as strong in elderly people as in youth. In institutions so much of the staff's time and energy is expended on actual physical care of the inmates that little, if any, is left for satisfying these other needs.

Dr. Howard Rusk reports that 90 per cent of people who have had strokes can be trained to self-care and ambulation and one-third can be placed again in gainful employment. How can all these requirements be met? An occupational therapist might visit them and seek to arouse their interest in some type of work which would not only serve as rehabilitation but also provide extra pocket money from the sale of articles. Some institutions have started arts and crafts projects, also music and reading clubs. In some instances invitations are sent out to the older residents in the community to attend entertainments in the Home, thus providing a nucleus for community senior citizen recreational programs.

In one such home in England a society collects broken toys and dolls; the men repair them while the women dress the dolls. The children from "the wrong side of the tracks" are then brought in and receive the gifts.

The greatest progress in housing schemes for senior citizens has been made in England. There are both one-storey flats and "hostels" capable of housing 40 people. These are not built in isolated sections but where the dwellers still feel that they are part of the community. A doctor remarked in this connection, "They don't want to be forever looking at the funerals of their friends. They need to see the baby carriages too!"

Some features of these homes are:

Adequate heating, good hot water supply, all shelves within easy reach, handrails and a bell near the bath and the bed, connecting with the next house in case of sudden illness.

No dark corners. Window sills low

Sister MacKenzie is from the Hôtel Dieu, Chatham, N.B.

enough so that the old folk may see out easily while seated; the sills wide enough to hold flower pots.

The front door should not open directly into the living room to avoid draughts.

In Denmark, Sweden, and Holland, extensive town planning for the seniors has taken place. These units consist of 2- and 3-room single storey buildings constructed especially for the aged in close proximity to church, recreational centres, stores. They also include a nursing unit. Help for laundry and heavy cleaning is provided. These accommodations are available at a rate in keeping with the financial status of the older folk so that they are assured comfort and some cash in their pockets.

In Canada the high cost of construction has seriously deterred action in this line. However, some communities have combined financial assistance from provincial and municipal governments with funds raised by local service clubs and community organizations to construct or renovate suitable, low rental accommodation. Burlington and Owen Sound in Ontario have built apartment blocks for both single and married elderly people; in Burnaby and New Westminster, British Columbia, there are cottage-style duplexes. Much remains to be done and the fundamental responsibility for all of us is, first to understand our senior citizen and second, to prepare now to become the useful senior citizen of tomorrow. "The thermostat of true aging is set in one's own mind."

Employment among Older People

SISTER ST. KEVIN

DR. W. G. SCOTT, employment adviser for Ontario began a speech with this verse:

In heathen times, when skulls were thick,
did primal passions rage.
They had a method, sure and quick,
to cure the blight of age.
If one's native youth had fled
and time had sapped his vim,
They simply popped him on the head.
That was the last of him!
But in this our enlightened age,
we're made of finer stuff,
And so we look with righteous rage
on methods crude and tough.
Thus, when a man grows old and grey,
and bent and short of breath,
We simply take his job away
and let him starve to death!

Naturally, we frown on such a thought but if we will examine what is happening we will find that it is often true. By living so long, the older worker considers he has committed the blunder of his life for he has passed an age limit for employment — too old to qualify, too young to die! He may believe he cannot do anything any more. He just sits and waits and grumbles. There we have a national problem. The older worker may want to keep on working and he may be able to turn in a good day's work but on the 65th anniversary of his birth he is "honored" by his associates, presented with a gold time-piece — so he can watch his life tick away — and then turned out to pasture. Age should present no such barrier.

All of us tend to fall into the error of considering everyone beyond a certain age as "old" although, interestingly enough, our ideas on the subject tend to change significantly as we pass each decade ourselves. Today a man of 65 may be as young, vigorous and vital as another man of 40. Unhappily, he often is considered as old, tired, weak and miserable as a man of 80. We all know people who, though they have passed their 70th or 80th milestone, are mentally agile and youthful in outlook. For example, we have Sir Winston Churchill and our own prime minister, Louis St. Laurent.

Sister St. Kevin is at the General Hospital, Sault Ste. Marie, Ont.

For the individual, the psychological consequences of being continually refused employment because of age are very serious. The frustrations resulting from being unable to use his skill, experience and training, of being denied a means of self-support and of feeling that there is no place for him in society, are bound to crowd our mental hospitals and increase the case load of outpatient clinics. Life is prolonged by work that is enjoyed and is geared to one's capacity.

However, many employers argue that older workers experience a loss of skills and physical decline. In this problem there are individual differences to be considered. It was discovered by many Canadian employers during World War II that the older worker's accident rate was better than that of any other age group. Workers between the ages of 70 and 74 were by far the best with 320 disabling injuries per million work hours as compared to 1,500 for the 20 to 30 age group. Is the problem of the older worker to be solved only in times of full production or war? Can he not work in times of peace as well and receive consideration from the employer and younger workers?

Emphasis is placed upon the faculties an individual lacks — regardless of whether they are needed for the particular job — rather than on those he possesses. Full recognition has not been given to the fact that very few jobs require all human faculties. The old worker should be given a fair chance.

"I want to keep working," says one oldtimer. "No more work for me! I want to take it easy," says another. So we have the issue of work versus retirement. A solution that has been recommended is that counselling, whether for retirement or work, should be offered early so that the worker will be properly prepared to make his choice. If it is retirement, a pension should be available to insure security. If it is work he chooses, supervision should be provided so that as his physical and mental condition changes he would be reassigned to positions that would utilize experience and training rather than strength and agility. The older worker has his own special weaknesses and his own special qualifications. His experience and stability are required as much as the fresh approach and enthusiasm of youth. He needs the opportunity to work and the assurance of a useful place in society with the promise of security that is offered through retirement pension schemes.

A new ruling for federal civil servants establishes no age limit for retirement. So far as I know, no industries in Canada have taken this step. In the United States a rug industry has adopted the plan of a full pension at 65 years of age with pensions of reduced amounts at 60. Between the ages of 60 and 68, retirement is at the option of the employee; between 68 and 72, retirement is by agreement between management and union, and finally from 72 years on, the option is with the employer. We hope that this plan will be adopted by other industries.

Community Recreation

While loneliness can be common to all the elderly, there should be a well planned program to meet the needs, difficulties and possibilities of senior citizens. However, providing a program is not enough. The public in general needs first to change its attitude towards the aged. The senior citizens themselves need to be trained toward responsibility for their own program. For those who are alone in the world, and who fancy they are not wanted, a club can fill their needs and give them something to do for others. They can learn skills or teach others, and act on committees. This club would provide the friendships so many older people lack either because death has taken their former friends or because they find the business world has rejected them. Their advice is not usually wanted by the younger folk. If they try to speak in a meeting of mixed ages their ideas are often smiled at.

A club for senior citizens has the advantages of making each one feel that his ideas matter. They are free to choose their own amusements. Handi-

work, games or working in a "Tinker Shop" are just a few of the activities available. In 1952 a survey was made to discover the popular activities of the older group. "Entertainment by their own members" was first on the list with crafts last. As far as games were concerned bingo seemed to be the most popular. The aged are easily entertained, but a little encouragement could be given by arranging hobby shows and giving the members an opportunity to sell what they have made, thus obtaining those little extras.

These clubs are, as a rule, difficult to organize. The first important step is the choice of a good leader. Persons to avoid are:

The *mother hen* type — reminding the older people that they are fragile and incapable of doing much.

The *autocrat* — who wants to rule.

The *bleeding heart* — who exclaims about the poor, dear old people, and tells her friends about the good she is doing these unhappy souls.

The *hit and run* leader — who is either so careless or so busy that she puts very little time or effort into her planning and consequently the club suffers.

A good leader is one who will have as a goal full democratic participation in the planning and administration of the club's affairs.

Consideration of a meeting place, conveniently situated and with ample room, presents a problem. Since many senior citizens have helped in the past to support our schools could they not take possession of the school auditorium or a few classrooms in the evening? This perhaps would serve the purpose very well until a private building could be found. Every community must feel their responsibility in this matter. A city could be divided into sections, each with a Senior Citizen Club. In this way recreation and a little health teaching could be provided which would enable us to build a healthier and happier older population.

Annual Meeting in Manitoba

THE 40TH ANNUAL MEETING of the Manitoba Association of Registered Nurses was held September 29, 30 and October 1, 1954, in the Royal Alexandra Hotel, Winnipeg, conjointly with the annual meetings of the Associated Hospitals of Manitoba and kindred bodies. The program consisted of three business sessions, three interest sessions, and the final annual dinner. Reports given during the meeting revealed unusual activity during the past year in relation to the formation of district associations and in educational programs. Regarding the latter, the report of the executive secretary stated — "Mindful that the unparalleled demands of our tragic polio epidemic involved a large percentage of our members in emergency services until late November 1953, it is nothing short of amazing that so much could de done, in addition to normal duties, by nurses in full-time employment." Eight institutes were held between November 1953 and September 1954.

The instructors who attended the institute on poliomyelitis nursing subsequently conducted classes for nurses in their respective hospitals, health agencies and communities, namely: Flin Flon, The Pas, Brandon and Greater Winnipeg.

"C.N.A. Round-up, 1954," was presented by a group of Manitoba nurses who had attended the biennial meeting of the Canadian Nurses' Association in Banff. Their recollections were skilfully enlivened by colored slides taken by several members who attended.

Mrs. Frances Kreuter, associate professor of education, Teachers College, Columbia University, addressed a general session on September 30, her subject being "The Undeveloped Potentials of Nursing Care." Mrs. Kreuter spoke of some of the conclusions drawn from a study of the function of nursing in which she has participated during the past four years. In suggesting that it is necessary to consider the function of nursing in terms of elementary, technical and professional skill, Mrs. Kreuter used a dramatic script to demonstrate the skills of perception and action in caring for a patient at these levels of nursing ability.

A very large audience attended a panel discussion on "The Professional Nurse and Labor Legislation." Miss M. E. Wilson was

(Concluded on page 58)

NURSING SERVICE

The Head Nurse Study

MARION E. BOTSFORD

A résumé of the report of The Head Nurse Study prepared by the Research Division of the Department of National Health and Welfare, with some comments concerning its implications.

A STUDY OF THE FUNCTIONS and activities of head nurses in a general hospital was planned and conducted by the Research Division, at the request of the Canadian Nurses' Association and with the cooperation of the Ottawa Civic Hospital.

This was initiated as a pilot study with the thought of developing a suitable methodology for the investigation of nursing functions in a hospital. The head nurse in a general hospital was selected for two reasons:

1. More than half of employed nurses in Canada are in hospitals, the majority in general hospitals.
2. The head nurse is a key person in the hospital service as she is at the centre of relationships between the patient, the doctor, the nurse and hospital administration.

The stated *purpose* of the study was to answer the following questions:

1. What does the head nurse do?
2. How frequently does she carry out various activities?
3. What proportion of her time is spent in activities of different types?
4. Is she performing any duties from which she could be relieved?

The responsibility for planning and directing the project, which began in 1951, was assigned to the supervisor of the Methods and Analysis Section of the Research Division, assisted by a member of the Research staff who had a major responsibility for the field work and coding of the data, and who served as one of the four observers.

At the request of the C.N.A. a nurse was engaged by the Research Division for a period of three months in 1951 to act as liaison officer between the hospital and the Division and to provide assistance on technical details of nursing practice. She also was one of the observers. The chairman of the C.N.A. committee on the Provision of Nursing Care and the nursing consultant of the Department of National Health and Welfare were nursing consultants for the study.

The Ottawa Civic Hospital was selected by the C.N.A. because of its location, its size (850 beds) and general nature, and particularly because the superintendent of the hospital and the director of nursing were interested in the project and willing to cooperate. Two members of the nursing administration staff acted as observers. It is stressed in the report however, that this study is not a critical analysis of the nursing service of the Ottawa Civic Hospital.

Before any observations were made a meeting of all the head nurses was arranged at which the members of the research team explained the purpose of the study; the way in which the observations would be made; and the part the head nurse herself would be

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Mrs. Botsford was chosen by the C.N.A. to assist with the Head Nurse Study. She is assistant registrar of the Registered Nurses' Association of British Columbia.

expected to play in carrying out her duties in a normal manner. She was asked, also, to explain the purpose of any activity if this was not obvious. For example, she might take a bouquet of flowers to a patient, not primarily for the purpose of transporting the flowers, but because she wished to see that particular patient at that particular time and wished to have a reason for doing so which was apparent to the patient.

It is felt that the time spent in gaining the intelligent cooperation of the personnel to be observed is an important aspect of any study of this nature.

General Plan of the Study

1. A *schedule of observations* was drawn up to cover 120 observation hours randomly distributed over a 10-day period, Monday to Friday of two consecutive weeks.

a. Each head nurse was observed for 8 one-hour periods.
b. The 8 hours for each head nurse covered a full 12-hour hospital day.
c. Each head nurse was observed by each of the 4 observers for 2 periods.

There was a maximum of 3 observation periods in a day for each head nurse and a maximum of 5 observation periods in a day for an observer; 15 head nurses were observed. Special departments such as maternity, the outpatient department and the operating room were omitted.

2. In view of the purpose of the investigation a time and motion study was not appropriate. It was felt that activity should be considered as *purposive action of a specific nature.* A form was designed to record the activities of the head nurse during each quarter minute of observation and it included reference to related factors such as the location, persons and/or equipment involved, and the general topic of conversation.

The observations were made in the fall of the year after the school of nursing began its term. Timing was done by stop watch. The observers followed the head nurse closely enough to be aware of all activities and the content of the conversation. A simple code was evolved for recording the observations but no coding of activities was done at the observation stage.

3. *Procedure for analysis:* Classifications and codes were devised which divided the functions and activities carried on by the head nurses into three main areas:

Patient care
Ward administration or housekeeping
Personnel administration

In each of these three areas the activities were classified into five levels of function:

Management
Education or teaching
Supervision
Direction
Execution

About 250 specific functions or activities were listed.

The coding was done directly on the observation sheets by the member of the Research Division who was one of the observers. Marginally punched cards were used for tabulating the results. These could be sorted by activity code number, by frequency, by ward, by observer and other variables.

Analysis of the Data

1. *Duration and frequency of activities:* Activities were timed to the nearest quarter minute so that, in the 120 hours of observation there were 28,800 fifteen-second intervals; 14,028 activities were observed in this time. This means that the head nurses were engaged in activities which averaged ½ minute in duration and it was found that half of the activities were less than ¼ minute in duration. 93 per cent of the activities lasted one minute or less and this represented 70 per cent of the total time.

The importance of this extremely low average duration of activities of ½ minute cannot be overemphasized. Why can the head nurse spend on the average only ½ minute in one activity? Is the fact that her activities are so broken up by her involvement in the general work of the ward a result of hospital policies, general administration policies, nursing administration policies, size and layout of the nursing unit, physical facilities of the unit, lack of proper equipment, inadequate as-

sistance for the head nurse, or inadequate preparation for head nurse duties?

The rapid shifting from one activity to another seems inconsistent with the proper responsibility of the head nurse for over-all planning and control of the work in her unit. It suggests instead that she is constantly being overwhelmed with the detail of ward routines; that she is not in control of the situation, but that her activities are a function of the circumstances in which she finds herself and for which she is inadequately equipped by training, experience or authority to deal.

2. *Nature of activities:* About 75 per cent of the head nurse's time was concerned with patient care, 15 per cent with ward administration and housekeeping, and 10 per cent with personnel administration. The activities were of consistently short duration in each of the three areas.

3. *Time spent in various levels of responsibility:* The head nurse was herself directly engaged in carrying out routine activities on the ward as outlined in the code for ⅔ of her time whereas 30 per cent of her time was spent on management, supervision and directional functions (functions consistent with the idea of the head nurse as administrator of a unit).

In the direct activity area a little less than half of the time was spent on ward routines and the balance on administrative and clerical duties. The fact that more than ⅓ of her time was spent completing forms and on other clerical duties calls for particular comment because in the Ottawa Civic Hospital ward clerks are available on all wards from 9:00 a.m. to 5:00 p.m. to assist the head nurse.

It must be recognized, however, that some of the clerical duties are more administrative than clerical involving liaison with senior personnel as well as with other hospital departments, e.g., writing day and night reports, making rounds independently, etc.

Are hospital and nursing administrators aware of the fact that so much time is being devoted to clerical work by the head nurse? How can she be relieved of such duties? Should the number of ward clerks be increased and the periods of their duty extended to evening and even night duty? Is there a place for administrative assistance such as an executive assistant to the head nurse? If so, what should be her preparation? What her duties and responsibilities? Should responsibilities for business administrative procedure, including such items as vouchers, be assigned to nursing personnel or should this be a clerical responsibility under the direction of business administration?

Turning now to consideration of higher level functions, we find that 17 per cent of the head nurse's time and activities were concerned with supervision, while 5 per cent of her time and 7 per cent of activities were concerned with directing the activities of other persons. The important function of management, planning and organizing the work of her ward, accounted for only 8 per cent of her time and 6 per cent of her activities. There was a small amount of time (4 per cent of time and 3 per cent of activities) left to be divided between education of the patient and of her staff.

The need for expanding the higher level functions of the head nurse is clearly indicated by these figures. Less than 10 per cent of her time was devoted to organizing not only the patient-care program but also the ward maintenance and personnel for which she has responsibility. Approximately ⅕ of her time was taken up in explaining the duties to her staff and seeing that these duties were carried out. As has been noted, there was very little time left for educational procedures on the ward.

This shortage of time for higher level functions suggests other queries. Can the head nurse delegate her work? Does she know how to do this and is the opportunity actually present? Should she spend more time with the assistant head nurse and the ward clerk to direct and therefore make the best use of their services? If the assistant head nurse is regarded as a full-time staff nurse when the head nurse is present can she be a full-time assistant at the same time? Are the

personnel to whom the head nurse might delegate activities now fully engaged in routine activities? If so, how could they assume further responsibilities? Are they able, in terms of qualifications and training, to assume delegated duties? Do we know whether the head nurse is adequately prepared for this position of leadership where she must deal with a high nurse turnover, increased use of auxiliary personnel, increased complexity of medical treatment, etc., and where she must apply principles of good administration including delegation of duties? This would appear to be one of the fundamental issues to be considered.

Another question for consideration is: Should there be a separation of nursing management from other hospital service management at the head nurse level? If so, what could be the effect on the satisfaction of nurses? Would this division of management set up potential areas of friction?

Specific Kinds of Activities

In the area of patient care, observing and recognizing general symptoms, investigating specific symptoms of disease, mental hygiene of the patient, discussing the patient's condition with medical and nursing staffs (including day and night reports), reviewing doctor's orders and prescriptions and transcribing entries to the Kardex, were the most common activities.

In the maintenance area, the only common activity was securing, distributing and storing supplies on the ward.

Checking on the whereabouts of staff was a leading activity in terms of most time in the personnel administration area.

The most frequent of these activities (observing and recognizing general symptoms and conditions), occurred almost 500 times or nearly 4 per cent of the total activities, reflecting the close attention given to individual patients by the head nurse.

The use of the head nurse's time for securing, distributing and storing supplies, and looking for staff, needs investigation from the standpoint of efficiency of general administration. Are these procedures indicative of the utilization of personnel according to their capacity and training? Is it a head nurse function, or even a nursing responsibility to secure, distribute or store supplies, or to look for personnel? Is it the responsibility of the administration to consider messenger service or adequate types of signalling or other devices? Another point for consideration is making Kardex entries. Does this function require a head nurse or could it be delegated to the ward clerk with head nurse supervision?

Activities Requiring the most Time

The ten leading activities in terms of the head nurse's time included those mentioned above and five others. In the patient-care area, making arrangements and writing orders for laboratory services, writing day and night reports, supervising the administration of drugs and medications, and assisting the physician on rounds to patients were noted. The only additional activity was in the area of personnel administration — that of arranging the times on and off duty for nursing personnel, a management function.

The activity requiring the most time of all — giving day and night reports — took 4½ hours or 3.8 per cent of the time. On many occasions while giving the report the head nurse was interrupted with the result that the average uninterrupted time for this procedure was less than 2 minutes.

The writing of the day and night report and presentation of these reports constitutes one of the few opportunities for the head nurse to examine and discuss the patients and the general work of her ward. With constant interruptions this over-all view tends to be lost in the short-term consideration of detailed items which is all she normally has time for. With more time free to prepare an adequate report and to discuss the implications of it with the nurses, we might expect the head nurse to give better interpretation and direction to the work of her ward. This should lead to fewer interruptions during her working day. It cannot be questioned that the head nurse, as the

ward administrator, should have time to sit down, to think and to plan. At present in this situation, she has no such opportunity due chiefly to the fact that she is interrupted on the average of every ½ minute. What effect on the number of interruptions would the introduction of team nursing have?

C.N.A. Allocation of Activities

A review of the classification of activities was made in order to indicate who should carry out each specific activity, e.g., the head nurse, staff nurse, ward clerk or nurse aide. This was done by a committee of the C.N.A. and reviewed in detail by the two nursing consultants and the two members of the Research Division. The allocation of activities according to status was done from the classification with no reference to the study data and from this standpoint, at least, was unbiased.

When the activities were analyzed according to this criterion it was found that the head nurses' time was divided as follows:

5 per cent on activities that the C.N.A. regarded as appropriate to the head nurse.

15 per cent on staff nurse duties.

4 per cent on nursing assistant duties.

6 per cent on ward aide activities.

17 per cent on ward clerk duties.

A small and negligible amount of time was spent on duties appropriate to instructors and supervisors. If only 57 per cent, less than ⅔, of the time of the head nurse is spent on work appropriate to her status, it would seem important that we give attention to means of increasing this percentage.

There are many questions to be answered, not the least important of which is: Are hospital and nursing administrators themselves adequately prepared to make an analysis of job specifications and personnel requirements for nursing service units, in relation to the requirements of the present-day patient and what is involved in his care? Elsewhere many hospitals have carried out practical studies of this nature which have resulted in general reorganization of hospital nursing service.

Re-allocation of functions should not only be viewed in terms of delegation of duties by the head nurse. Perhaps she needs to be relieved of functions and assisted more by the nursing and other administrative staff. Should more be done by way of central planning of regular functions common to all wards — for example, the preparation of assignment and rotation schedules? If routine requirements were clearly and simply set out in detail, then the head nurse might be free to mobilize the nursing resources on the ward, to deal with emergencies as they arise, and to plan improvements in the quality of patient care which is her primary responsibility.

Finally, the need for quantitative standards for the evaluation of head nurse activities must be emphasized. In addition to the authoritative statements of what the head nurse should or should not do, we need to know what relative amount of her time should be devoted to approved activities. This applies also to other categories of nursing personnel and represents a field for further study.

Summary of Conclusions

1. The study provides a comprehensive and detailed picture of the functions and activities of head nurses observed while in charge of all types of wards (except maternity) of a large general hospital. It answers the questions posed initially as to the frequency and duration of activities of various kinds; the activities are described in terms of area, level, and about 250 specific categories. The description includes reference to places, persons, forms and equipment. It is unbiased with respect to observers and head nurses.

2. This was a pilot project and a methodology was developed which seemed adequate for the purpose, is reproducible and applicable to other studies of this kind and, with modifications, to the investigation of other members of the nursing staff.

3. The allocation of functions to the appropriate nurse status by the C.N.A. provides a new and authoritative basis for further research in the evaluation of nursing functions.

4. The consistency of the pattern of activity among head nurses on all types of wards is significant as indicating the fundamental nature of the description presented in the study. It should serve as a sound basis for planning any changes considered wise or necessary.

5. In view of the importance of the possibility of delegation of head nurse activities, the investigation of the functions of other members of the nursing and auxiliary staffs would seem to be a fruitful field for further research.

Our pilot study has been completed. Copies of the full report are available from national and provincial offices. Its value will depend, to a large extent, on whether or not its findings serve to stimulate the investigation of nursing functions and activities in other specific situations. Are we going to use it in order to plan efficiently for the most effective use of our limited nursing resources?

Solving Hospital Problems

MARION J. WRIGHT, M.S.

(Concluded from the December, 1954 issue)

HERE MIGHT BE A GOOD PLACE to digress and tell you about some other things that were going on while we were gathering together our data. We were very fortunate to have a committee appointed by the Detroit Chapter of the Society for the Advancement of Management to work with us on this project. They stated their over-all purpose was to help us to help ourselves. They met frequently and assisted us with our program. I will briefly outline what that program was:

1. They helped us to set up a 12-hour class in work simplification. The first class was given as a pilot study to top administration and department heads in the hospital. They then taught three of our own people to give these classes. The first time our own personnel gave their classes, they acted as critics and helped them to improve their methods. Since that time we have given these work simplification classes to all of our supervisors. It was done on an in-service education basis.

2. They helped us set up a course in supervisory refresher programs.

3. A group of men made some pilot studies to show people how work simplification operated — for instance on methods of stockpiling and delivering equipment; a more economical linen delivery service. They also gave us assistance when we began to discuss skilled jobs and to set up new job classifications.

4. They were our advisers on the work sampling, helped us to set up our forms, taught our observers how to make their observations and taught me how to tabulate and analyze the study. You will note that they did not come in to do much of the work — only to show us what could be done by pilot changes and to help us to help ourselves. They were consulting all along with us and our whole study and plan had the industrial engineering approach.

Now we were ready to set up a new plan. We had a joint committee of nursing and housekeeping personnel to find out what housekeeping duties nursing was still performing — and when I speak of nursing, I do not always mean graduate nurses. These were some of the things we gave to the housekeeping department — the complete responsibility for check-outs, ward tidiness, the inside and outside of bedside tables, the cleaning of all cupboards, except the narcotic cupboard, the cleaning of the utility rooms. Previously they did the floors and the sterilizers, now they were responsible for cupboards, tables, washing and sterilizing wash basins and bedpans,

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the care of the flowers. In the operating room, they helped the nurses clean up a room after surgery, mopped the floors between cases, helped the nurses reset the room, cleaned the cupboards and things of that sort. In the central supply room they were washing tubing, washing glassware and jobs of that kind.

We found that in dietetics some functions could be taken over. For instance, the waitress function on the unit; a dietary team was set up that starts on the top floor, serves trays, goes to the next floor. When the bottom floor is through eating, they go up and collect trays. Nursing still feeds the patients, sees that they eat, prepares them to eat and makes them comfortable afterwards.

We set up a system of exchange linen carts. Previously the head nurse had to make out a requisition daily. When the linen was brought up in big carts for three or four floors at once, nursing had put it on the shelves, checked to see that they had received the right amount of linen, then someone made an individual pack for each patient. Now each floor has two carts. We've ripped out all the shelves in our linen room. Each floor also has a floor standard of linen. We eliminated the daily requisitions. The linen room supervisor is responsible to see that the standard is on the cart. We've eliminated the counting of linen. The cart is so arranged that the sheets, the draw sheets, and the towels are in order of use and each day the cart is just taken down to the floor and a sheet, a draw sheet and a towel are taken off. We eliminated making the packs. In the laundry, these carts can be filled right from the mangle, therefore we have eliminated an extra step down there. You might ask, "But what if you need more than that standard?" If we have a patient whose care demands more linen, the head nurse just sends the note down — "add ten extra sheets." When the emergency is over — another note goes down "discontinue the ten extra sheets."

On the basis of our activity analyses, we set up standards of floor supplies. All equipment is prepared in one central place. The Central Supply Room worker goes to each unit three times a day, takes away the dirty equipment and puts in fresh. This has eliminated requisitions, special slips and special trips to the supply room. We found that our nurses were running all over the hospital and were off the floors a good part of the time. We set up a central messenger and escort service that does about 8,000 trips a month. Before, roughly 5,000 of these trips had been done by personnel taught to take care of patients.

Our 22 units were sending someone down to the pharmacy each day for drugs — a trip that averaged 20 minutes. It was usually the head nurse because everybody else was too busy to go. Now we have a pharmacy delivery service. This has led to prepackaged drugs in the pharmacy, has eliminated work down there and has saved 68 man-hours of time in a week.

We started first on the interdepartmental reorganization of functions. We next turned our eyes to the personnel. Who was to do what? We looked at the practical nurse and found that we had not been allowing her to do everything she had been taught in the practical nurse school — so we said, she can do all of these things except, at the present time, give medications. We had no inservice trained aides; we had ward helpers who passed wash water, mouth wash and made empty beds and that was about the extent of their service. We developed the job of the nurses' aide. We give her 80 hours of training, classes, demonstrations, return demonstrations and practise under supervision. She now can give bedside care to the convalescent and ambulatory and do simple treatments such as hot water bottles, ice bags, throat irrigations and things of that sort. We already had ward clerks, but could their functions be extended? Yes, they could post doctors' orders, make up the Kardex, write out medicine tickets, under the checking and supervision of the head nurse. They fill in x-ray slips, laboratory slips, answer the telephone, chart temperature, pulse and respiration, chart the doctors' visits. In fact, they do all the clerical work except for

the head nurse's planning of the workers' time and the actual charting of nurses' observations on the nurses' notes. We also decided that the practical nurse could do her own charting.

In the meantime our nursing procedure committee had been busy reviewing our nursing procedures in terms of work simplification. So far they have close to 50 of these procedures simplified. In areas where mechanical equipment could be used, such as needle cleaners, glove powderers and washers, syringe washers, multiple syringe containers, all of these things were investigated and put to use. I know what the hospital people are going to say. "Didn't that equipment cost you a great deal of money?" Yes, we had to spend money, but we have records to show how soon the equipment purchased would be amortized by releasing people for other jobs. For instance, the syringe washer and the needle cleaner has eliminated one whole 8-hour job. The glove powderer has eliminated one job in the unit that is washing the gloves in the washing machine, putting them into the dryer and powdering them. On that basis it doesn't take long to amortize equipment.

On the linen carts we were able to cut down the delivery time of linens 50 per cent, plus the nursing time saved that we should never have spared in the first place. Many other things are going on and it would take too long now to list all of them, but this gives you some idea.

Now we were ready to set up a test unit with a test staffing pattern and this is the way it went. It was decided to use what is commonly called team nursing. Our people did not take to that term very well. Because they had been participating in the whole program we asked them what they suggested. They thought team nursing was something special or different. So we said, "How about group nursing?" Believe me, it's just a rose by another name. Our teams or groups consist of:

1. The *graduate nurse*, the focal person who gives bedside care to the critically ill, performs complicated treatments — about 44 per cent of the total — gives medicines, observes and interprets to the doctor not only physical signs but emotional manifestations. She plans, organizes, delegates duties and supervises the work of the non-professional members. She does health teaching. The final responsibility for the nursing care of the patient is hers. The patients are assigned to her, the non-professional workers are assigned to her and together they plan the total care of the patient.

2. The *practical nurse* is an important person in the group. Her list of duties is long, depending to some extent on what the diagnosis is. However, more stress is placed on the condition of the patient. She gives about 20 per cent of the patient care and about 36 per cent of the treatments.

3. The third classification is the *aide*. She gives bedside care to the convalescents and the ambulatory patients. She does the simple treatments that I mentioned before. In fact, she can do about 30 per cent of the treatments.

4. The *ward clerk* is not actually a member of the group. She might serve one or two groups, plus acting almost as an administrative assistant to the head nurse, because she has taken over all of this clerical work. Also, I forgot to mention, we set up standards of expendable equipment, such as pencils, soap, etc. The clerk checks all of these, makes out all of the requisitions for the head nurse's signature. Because of the various functions she has taken over, we have been able to eliminate the position of assistant head nurse.

How many patients are assigned to each team? It differs by service. We found on the surgical service that one graduate, one practical and two aides could take care of 18 to 20 patients. On medicine, because we had more acutely ill patients, one graduate could only be responsible for about 15 patients, with a practical nurse and an aide. On pediatrics, one graduate could only be responsible for about 13 patients, with either a practical or an aide, or two aides.

The staffing plan has to be set up based on what the patients are like. The question doubtless enters your mind, "What is your percentage of

professional to non-professional staff?" Without counting supervision, on a hospital-wide basis, it is about one professional to two non-professionals; including our supervision, it is about a one to one ratio. In supervision we include head nurses, supervisors, instructors, nursing office personnel and anyone above the level of the graduate staff nurse.

Graduates from our present schools of nursing are not educated to be group or team leaders. It has necessitated a tremendous inservice education program to give them the supervisory and teaching skills needed to assume this position. But as they become a group leader, we have rewarded them financially.

I said, on an over-all basis, it was a one to two ratio. That again differs from service to service. For instance, on the surgical service we plan for 20 per cent professional, without counting supervision; on the medical service, 52 per cent professional. If we had a non-segregated service, it would probably be about 30 per cent professional. On obstetrics we only need 20 per cent professional. What are the results of this study?

1. Staffing patterns based on using the professional personnel for only those jobs that demand their skills. Their services have been extended over a wider range of patients thereby giving people more care which is important economically.

2. The improvement of methods which means, financially, a saving. We do not have any actual figures that we are willing to quote yet, but we think it will.

3. Improvement of employee morale.

4. Improved quality of patient care.

How can I make these claims? After the test unit had been running for several weeks, we re-evaluated all of our statistics; the activities analyses; the time studies; to see if people were doing what we had planned to do. We also re-evaluated the patient satisfaction. It is on that basis that I say these are our accomplishments. When we started this study, Harper Hospital had 559 patient beds in use. We now have 635, and we do not have any more graduate nurses than we had before. I won't say we have all we need to have our plan working perfectly. We still are short about 15 graduate nurses.

Are these principles only applicable to the hospital? No, they are applicable to any kind of nursing — public health, office, industrial, etc. What are you nurses doing that someone else less trained could be doing, so that you could take care of more patients?

Industrial Preventive Medicine

Unless we can, through industry, harness the knowledge of medicine to prevent illness, to conquer disease, to control the damaging effects of the aging process, we will crumble the financial structure of industry by attempting to impose upon it an everincreasing cost for medical care. The practice of spending thousands of dollars in industry for cure, without concentrating every known tool of prevention just doesn't make sense.

This isn't the first time in the history of industrial management that practices were followed that do not make sense. But the history of nonsense in industrial practice has always been the same. Either sense is reintroduced and the result changed to dollars, which profited everybody, or the individual establishment closed its doors, to create another monument to unwise management... Now is the time to make prevention work. If we do, the future will belong to preventive medicine. Better health for the people will be the dividend payable. With this health they can enjoy the dollars now lost through the purchase of cure.

I ask you, isn't it a nobler objective to keep a man in a position in which he can buy steak, eat it, and feel that he owns the world, than it is to put a man into a position in which he can pay for a hospital room, eat a pill, and feel grateful to all his associates.

—A. M. Wilson, Health Insurance and Industry. *Industrial Medicine and Surgery, May, 1954.*

Most of us know how to say nothing. Few of us know when.

An Unusual Compound Presentation

WINIFRED E. M. ANDERSON

THIS IS THE INTERESTING case report of a 31 year old gravida iii para ii who was admitted in labor on August 18, 1954. Her expected date of confinement was August 10, 1954.

Previous obstetrical history: 1. 1942 — boy — weight eight pounds ten ounces. Duration of labor — nine hours. Forceps delivery. 2. 1944 — girl — weight seven pounds two ounces. Duration of labor — eight hours. Spontaneous delivery.

The puerperium was normal in each case.

PRESENT PREGNANCY

The prenatal period was normal throughout. On routine visits during the last trimester difficulty was encountered in determining the presentation. It was noted on succeeding visits that the presentation was vertex, then breech. On the last visit it was diagnosed as a floating vertex, the presenting part being easily palpated.

Labor began at 7:00 a.m. with regular contractions every fifteen minutes which gradually became more frequent.

On *admission* the contractions were coming every five minutes and lasting forty seconds. They were moderately good and not distressing to the patient. The uterus was relaxing normally between contractions.

Membranes were intact on admission.

Show not evident on admission.

Temperature: 98.2°, pulse 82, respirations 20.

Blood pressure: 112/74

Urinalysis: normal.

EXAMINATION

Inspection: the abdomen appeared normal in size for a pregnancy at term. The lie was undoubtedly a longitudinal one with no suggestion of it being oblique or transverse.

Palpation: Pawlik's manoeuvre revealed a broad and soft presenting part which was mobile above the pelvic brim. In the fundus in the left subcostal area a hard round mass suggestive of the head was palpable. Ballottement was not easily elicited, much in the same manner as with a breech.

Meanwhile the mother had volunteered the information that the fetus was an active one. She also stated that she was aware of a hardness under her ribs on the left side. It will be remembered that with a breech presentation the patient is usually more aware of the head in the fundus than she is of the breech with a vertex presentation.

Ausculation: The maximum intensity of the fetal heart in a breech presentation is usually heard at or above the level of the umbilicus until the breech engages. In this case the fetal heart was clearest to the left between the umbilicus and the symphysis and was regular at 136 beats per minute.

Examination: No presenting part could be felt in the pelvis and it was found impossible to reach the cervix to assess dilatation. The patient was examined by the attending obstetrician who felt that the breech was palpable in the fundus and to the patient's right, but that the vertex was not presenting at the brim; instead there was a broad soft mass as described.

On rectal examination the doctor had the impression of a soft conelike mass presenting and no dilatation of the cervix could be noted. The diagnosis of an abnormal presentation, possibly a shoulder, was made and an x-ray (flat plate) was ordered to confirm this. The x-ray report follows.

Treatment: Routine minor skin preparation. It is important to note that an enema was not given.

Miss Anderson, a graduate of the Royal Infirmary, Edinburgh, received her full qualifications in midwifery, including the Midwife's Teaching Diploma from Birmingham University, before coming to Canada. She is Supervisor of the Obstetrical Department, University of Alberta Hospital, Edmonton, Alta.

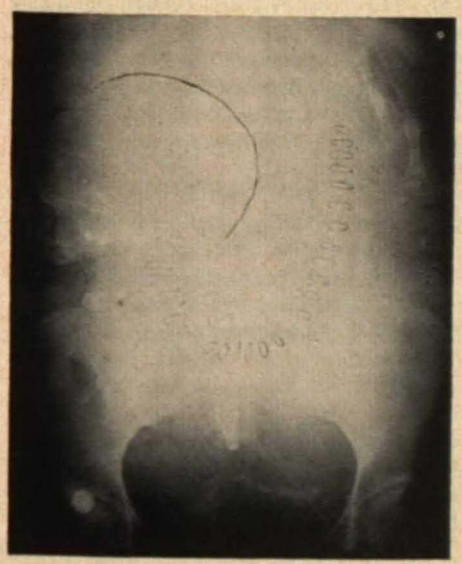
Progress

While awaiting the result of the x-ray the contractions became slightly stronger coming every three minutes and lasting sixty seconds. Spontaneous rupture of the membranes occurred at 2:45 p.m., seven and a half hours after the onset of labor. A quantity of pale yellowish liquor escaped. The uterus appeared smaller, the lie still appeared longitudinal. A rectal examination was done at once and a hand was felt prolapsed through the cervix. The fetal heart rate dropped to 112 beats per minute.

The patient was transferred to the case room and placed on the table in the Trendelenburg position in order to relieve pressure on the prolapsed hand and to prevent possible prolapse of the cord. Intermittent oxygen was given to her with contractions.

Vaginal examination at this time revealed the cervix to be four fingers dilated with the right hand, forearm and upper arm prolapsed into the vagina and one loop of pulsating cord also presenting over the internal os. At this time the attending obstetrician decided that further examination was only justifiable to determine dilatation and to see if flexion of the body could be carried out.

Findings indicated the futility of any attempt at vaginal manipulation and the patient was taken immediately to the operating room which had been alerted previously regarding an emergency Caesarean section.



X-Ray of Abdomen

The patient was cross-matched for 500 cc. of blood and an immediate hemoglobin was ordered. The report of this was 12.4 grams (85%).

The fetal heart now varied between 120 and 104 beats per minute.

X-ray Report

The x-ray report from a wet plate was now available and showed the following compound presentation:

> There is a single fetus in an attitude of extreme extension with the head lying in the left flank. The presenting part appears to be a hand. Apart from the fetal attitude no fetal abnormality is recognized. The soft tissue shadow of the placenta cannot be identified with certainty but probably lies in the fundus towards the right. The cause of the malpresentation is not obvious.

Caesarean Section

A further skin preparation of the abdomen was performed. An intramuscular injection of Hyoscine Hyperbromide, grains 1/150, was given before the patient was transferred to the operating room at 3:45 p.m. at which time the contractions were even stronger although there was still normal relaxation between. The patient was beginning to be distressed.

Under spinal anesthetic, Pontocaine 0.3%, a sub-umbilical, midline incision was made through the abdominal wall. The bladder flap was separated from the lower uterine segment. The latter was then encised vertically rather than transversely in order to facilitate delivery.

On entering the uterus, some meconium and a fair amount of liquor escaped. The fetus was delivered at 4:06 p.m. by breech extraction after securing one leg. The baby, a male, cried sponstaneously. Ergotrate 0.25 mgm. was given intravenously at the time of delivery of the head. The placenta and membranes separated and were expelled. On examination they were found to be complete.

The uterine incision was closed in

three layers. Blood loss was not excessive. The abdomen was closed in layers in the usual manner using plain 00 catgut double for the peritoneum and interrupted sutures for the fascia. Plain subcuticular and mattress silk sutures were used for the skin.

The patient's condition was good. A catheter was left in the bladder, for a period of twelve hours.

Post Partum

The mother recovered quickly. She had a moderate reactionary pyrexia from the second to the fourth post-operative day within the 99° to 100.2° range. Intramuscular Dicrysticin 2 cc. was given b.i.d. for three days following delivery and then discontinued. Routine Ergotrate, grains 1/320, was given t.i.d. for three days.

The patient was up on the third day post partum and walking about by the fourth day. Alternate skin sutures were removed on the sixth day and the remainder on the seventh day at which time the wound was healed and clean.

The baby, which weighed seven pounds one ounce at birth, showed some extension of the head but apart from being a little irritable, appeared normal. An initial weight loss of four ounces occurred in the first three days but once lactation was fully established, the baby commenced to regain weight and was six pounds fifteen ounces on the tenth day when it was discharged with its mother.

Teaching

This case has many unusual facets, several of which are particularly interesting from a teaching point of view:

1. The importance of *withholding a routine enema where the presenting part is high.* The lie was clinically longitudinal with no evidence of being transverse or oblique, and yet a compound presentation was discovered on rupture of the membranes. It would have been easy for the cord to prolapse with this type of presentation.
2. The importance of immediate rectal or vaginal *examination on the spontaneous rupture of membranes.*
3. A constant *check on the fetal heart* rate.

We were fortunate to have this patient in hospital when the membranes ruptured. Had this occurred at home, the results would certainly have been drastic with regard to the life of the baby. The mother's life could also have been endangered following obstructed labor with its sequelae of the formation of an excessively thinned out lower segment and possible uterine rupture. Vaginal delivery in this position would have been impossible.

Summary

In concluding this history one feels that an explanation of the cause might be attempted. This, however, can only be speculation. I recall a lecture that I heard some years ago where the theory was put forward that abnormal presentation need not always be attributed to pelvic or uterine abnormality of the mother. Supposing the fetus is extremely versatile or ambitious in itself — that could be responsible. The fetus in this case would appear to have been intended for an acrobat and may have moved to the left iliac fossa with the head extended just before the onset of labor. Is it not possible that good uterine contractions accentuated this position pushing the chest and abdomen downwards thus accounting for the presentation which was found?

Acknowledgement

I would like to express my thanks to Dr. Margaret M. Hutton for her assistance in preparing this report and to note that a somewhat similar case was described in *The Journal of Obstetrics and Gynecology of the British Empire* in 1951.

Arthritic patients receiving a high vitamin C intake showed no significant changes in joint swelling or mobility, but did show a significant decrease in pain, some improvement in well-being and appetite. The majority of 12 patients with multiple sclerosis treated with large doses of vitamin C showed subjective and objective improvement, an observation which appears to justify further investigation.

—L. J. Cass, W. S. Frederik, and J. D. Cohen, *Geriatrics 9:375*, Aug., 1954.

Teeth and Dental Caries

ANDREE HEBERT, B.Sc. in D.H.

THE SUM OF $48,400,000 was spent for dental services by the Canadian public during the fiscal year of 1951-52. This represents one-sixth of the total bill for all medical treatment including hospitalization for that period. One of the underlying causes for this enormous expenditure is the disease known as dental caries.

Dental caries is now regarded as a major public health problem. Even the novice among public health workers quickly admits as probably true, indeed as a fact, that 98 per cent of our population is affected by this condition. When the public health dentists of the province of Ontario conducted a survey among a selected group of school children, it was found that, among the six-year olds, 90 per cent of the children were affected by dental caries; two out of ten had lost teeth prematurely. In the two-year-old group, three out of ten had cavities, and in the four-year-old group, seven out of ten were afflicted with caries. Faced by these startling findings, what do we nurses know of this problem?

No one can deny the fact that the teeth and their supporting tissues are the least known and most poorly appreciated organs of our entire body. We fail to realize that their health and normal function play a vital role in the general wellbeing of the human organism. It is routine to look at the tongue and the tonsils for evidence of infection. Yet, how many of us know that the gingivae, also, will display signs of organic disturbance or of malnutrition, and that the teeth may become abscessed just as surely as the tonsils? Tonsillitis may heal of itself but dental caries will not. It may, sometimes, be self-limiting but will never be self-reparative. Like other parts of the body, infected teeth cannot function properly. Thus, healthy teeth are an important factor in the general health of the individual.

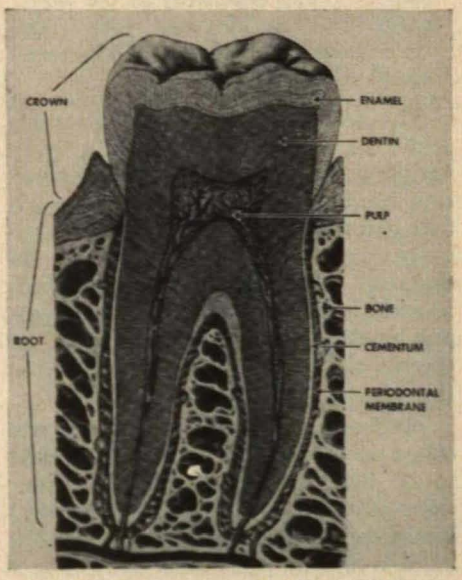
A graduate of Hôtel Dieu, Sherbrooke, Que., Miss Hebert secured training in dental hygiene and her B.S. in this field at Columbia University, New York. She joined the Faculty of Dentistry at the University of Toronto in 1951 as supervisor of courses in dental hygiene.

STRUCTURE OF TEETH

The teeth are hard, calcified bodies, firmly implanted in the alveolar sockets of the maxilla and the mandible. Anatomically the teeth are divided into two parts: the crown and the root. They are composed of three calcified tissues—(a) the enamel, (b) the dentine, (c) the cementum; and a non-calcified tissue: the pulp.

Enamel is the hardest and most highly calcified tissue of the body. Of varying thickness, it covers the entire surface of the crown of the tooth. The enamel forms a protective covering for the tooth, and its extreme hardness renders it fit for its function of mastication.

Dentine, also called primary dentine, forms the bulk of the tooth and gives it its characteristic form. It is a hard,



The Structure of a Tooth

ivory-like tissue that closely resembles bone. The secondary dentine is formed after complete calcification of a tooth. It acts as a barrier to dental caries slowing its progress. Chemical or thermal irritation that reaches the pulp may initiate and stimulate the formation of secondary dentine within the dental pulp.

Cementum is a dental tissue softer than the dentine. It covers the entire surface of the root of the tooth. Its principal function is to attach the tooth to the surrounding tissues.

Pulp occupies the central cavity of the tooth (pulp chamber) and the root canals. It is composed of embryonic connective tissue, blood vessels and nerves. The functions of the dental pulp are fourfold: to produce primary and secondary dentine; to furnish nourishment to the dentine; to give sensation to the tooth structures; and to regulate the blood supply of the pulp. Noyes et al[3] say that plup is: "...an extremely vascular tissue, and the arrangement of the vessels, the structure of their walls, and the nature of the intercellular substance through which they run render the tissue especially susceptible to the pathological conditions which are associated with alterations in the circulation . . . The delicacy of the walls of the blood vessels is one of the most striking histological characteristics of the dental pulp . . . This peculiarity of the blood vessel walls in the pulp renders the tissue unusually susceptible to hyperemia and inflammation."

The teeth, arranged in two arches with the upper arch slightly overhanging the lower one, perform certain functions. They seize, tear, crush, and grind the food so as to render it more accessible to the action of the digestive juices; they aid in speech by assisting in producing certain sounds; and finally, the teeth are essential for the normal growth and development of the jaw.

However, like bones, the heart, and other parts of the body, the teeth have to be healthy to perform their functions efficiently. Like these other parts of the body, they are vulnerable. The disease that they are most subject to is called dental caries.

Etiology of Dental Caries

The Michigan Workshop[2] defines dental caries as:

> A disease of the calcified tissues of the teeth. It is caused by acids resulting from the action of microorganisms on carbohydrates; is characterized by a decalcification of the inorganic portion, and is accompanied, or followed, by a disintegration of the organic substance of the tooth. The lesions of the disease predominantly occur in particular regions of the tooth, and their type is determined by the morphologic nature of the tissue in which they appear.

That is, dental caries is caused by an acid formed from the decomposition of the carbohydrates by the bacteria. Thus, three factors are essential to dental caries: teeth, bacteria, and carbohydrates. The teeth remain in the mouth as long as we care for them. Bacteria are normal inhabitants of the mouth. Carbohydrates are environmental factors introduced into the mouth through personal action. All three of these factors work together, but the role played by each individually can be altered to affect their combined action. So, we shall discuss them separately.

Teeth

We have already mentioned the structure of a normal tooth. The occlusal surfaces of molars and bicuspids contain grooves, pits and fissures. The pits are found not only on the occlusal surfaces of the posteriors but also on the lingual and the buccal surfaces of the cuspids, bicuspids, and molars. These irregularities are a contributing cause of decay because they act as food traps. They, as well as over-hanging fillings, irregular teeth, rough edges and loose contact points (points where the teeth touch side by side), are all hazards requiring close supervision on our part if dental caries is to be prevented.

Bacteria

Millions of bacteria are constantly present in the mouth. It is an ideal medium for their proliferation: it has darkness, humidity and heat. Kligler[1] estimates that an average of 10,500,000

microorganisms per milligram can be found in an immune mouth. This number increases up to 530,000,000 in cases of primary caries. Not all bacteria present in the mouth are pathogens. Nevertheless, under favorable conditions the acid-producing bacilli will proliferate and act upon the carbohydrates.

How is dental caries produced? One eats, for example, a piece of cherry pie or a chocolate bar. Little food particles catch between the teeth and in the other food traps. Within five minutes the pH of susceptible surfaces of teeth may drop from 6.4 or 7.2 to about 4 or 4.5. In this ideal pH the acid-forming microorganisms proliferate and become active. Through the action of their enzymes they ferment the carbohydrates and produce an organic acid strong enough to dissolve the inorganic portion of the enamel and dentine. Such activity lasts about thirty minutes, its peak being reached about five minutes after the ingestion of concentrated carbohydrates. At this first contact with the tooth surface the penetration of the enamel by the organic acid is initiated. Gradually a discoloration of the enamel appears owing to the breakdown of the protein. Then the weakened enamel collapses leaving a pin-point cavity. If left alone, additional carbohydrate intake may result in the production of more organic acid by bacteria which in turn will further dissolve the enamel until the cavity reaches the dentine.

At this stage, great discomfort may be felt, increasing as the cavity progresses towards the dental pulp. Also, secondary dentine is laid on the walls of the pulp chamber in an attempt, on the part of the pulp, to protect itself. If no attention is given to the cavity, the dentine will be penetrated, the dental pulp will become exposed and abscesses will appear.

If sweet food is taken at breakfast, at 10:00 a.m., at lunch, a couple of times during the afternoon, at dinner, and finally before going to bed, one can easily see that the teeth have spent most of the day, bathing in an acid solution. No wonder so many cavities are found among our people!

Carbohydrates

More and more evidence is found throughout the dental literature to support the theory that carbohydrates, especially in such concentrated forms as are found in candy and chocolate, have a direct influence on dental caries.

Studies were conducted to determine the caries incidence among primitive people and our civilized populations. Marked differences were found. Orr and Gilks[5] surveyed the physical and health conditions of the Masai and the Kikuyu. The diet of the first tribe consisted mostly of milk, meat and raw blood, while the other group ate mainly cereals, roots and fruits. The two tribes differed in height, build and general health, the former being superior. The dental examination showed:

> Of 254 Masai studied, only 1.6 per cent of the boys and 3.6 per cent of the girls had dental caries. Among the 2,500 Kikuyus, the incidence of dental caries was 13.7 for the boys and 13.1 for the girls . . . Mention should be made of the fact that even though the incidence of carious lesions was much higher in the Kikuyus than in the Masai, the incidence in the Kikuyus is still far below the extremely high incidence in the United States, the northern European countries, New Zealand, etc.

Similar findings are reported by Arkle[4] who has shown that Indians at James Bay in northeastern Canada experience more frequent dental caries the nearer they live to the trading posts and the missions. He reports that:

> There are 63.4% of the males and 66.6% of the females caries-free in the group living farthest from civilization, whereas only 17.1% of the males and 3.7% of the females are caries-free in the group living near or within the trading posts. The diet of the first group consists of fish, small game and birds, berries, flour and lard. The second group eats bread, biscuits, pie, cake, jams, jellies, with little meat, berries or vegetables.

During the past century in the United States, Canada and other countries, the increase in dental caries incidence has paralleled the consump-

tion of sugars. During the second world war, the marked reduction in the caries rate of many countries directly paralleled the availability of sugars.

Carbohydrates form the basis of modern diet. They provide an effective and cheap source of quick energy, have a pleasant taste, and are conveniently eaten at any time of day. Because of these qualities, too many people have come to accept carbohydrates as the most important thing to eat and drink, especially for children. Yet, they lack the minerals and vitamins essential to a well-balanced diet, besides having the bad effect of spoiling the appetite for nutritious, solid food. In reality their only contribution to the diet is quick energy — calories. In this country, there probably are few people who suffer a caloric deficiency.

As we already mentioned, 98 per cent of the Canadian population suffers from dental caries. Because an individual can rarely boast of having no cavities, we cannot expect the limited number of dentists now available to catch up on the national backlog of cavities unless we help them individually and collectively. The significant discovery of the relation of carbohydrates to caries has provided a splendid weapon in the fight to save our teeth. The first step in regulating the sugar intake is to eat more nutritious food and to make this food more satisfying by letting our appetites work up instead of weakening them by constant snacks. The aim is to use all foods more wisely for the benefit of the teeth as well as general health.

One concludes from the above statements that the teeth should be kept healthy since they are a factor in the general health of an individual. This health is possible only by:

First, keeping the dental surfaces free of defects and dental caries; a visit to the dentist twice a year is the only possible way to achieve this goal.

Second, reducing refined carbohydrate intake at meals and eliminating it completely between meals.

Third, brushing the teeth properly immediately after ingestion of food so as to remove all food particles and to stop the acid-forming bacterial action begun by eating.

For those who practise these three steps, the incidence of dental caries will be cut as much as 60 per cent.

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The Ten Commandments for Administrators

I. Thou shalt distinguish between occasions and trends.

II. Thou shalt not reprimand another whilst thou art mad, else that other and thou thyself become madder and reason be lost in the struggle.

III. Thou shalt present a kindly aspect to all other fellow employees.

IV. Thou shalt give no special privilege to one whom thou likest that thou wilt not give to all, whether thou likest them or not.

V. Thou must be the last one to lose thy head in an emergency.

VI. Thou shalt stop, look and listen to suggestion.

VII. Thou wilt show thy wisdom by acting as a mental waste-basket, if necessary.

VIII. Thou shalt "Let George do it" for thus only may he show that he can.

IX. When thou makest a decision seest thou to it that it is based on investigated facts and accumulated evidence.

X. Thou shalt acknowledge that time is the most expensive item in thy budget.

— Harold A. Zeally, *Modern Hospital*, May 1954.

NURSING EDUCATION

Discussing Administration

RUTH MORRISON, M.A.

THE REPORT OF THE Third Expert Committee on Nursing, in English and French, will be of interest to every Canadian nurse who has any administrative responsibility.

The Committee which prepared the report believes that every nurse who shares in providing nursing service or nursing education has administrative responsibility at some level and it recommends "that all programs of basic nursing education include some study and practice of principles of administration." Most of us who read *The Canadian Nurse* have already completed the basic course in nursing and for us the committee recommends study in administration appropriate to our needs through continuous in-service education, work conferences and advanced study programs.

The World Health Organization, national and provincial health departments, nursing service organizations, professional associations and universities can, and undoubtedly will, continue to publish material, offer courses and in many other ways endeavor to promote the study and understanding of administrative principles and practice in nursing, but real improvement can only be expected if the individual nurse is eager to improve her administrative ability in respect to her individual job.

May I now tell you something of the work and pleasure which went into the preparation of the report. There is an expert advisory panel on nursing to which nurses are appointed by the World Health Organization with the consent of member governments. Five Canadians are at present serving on this panel:

Miss N. Fidler, director, School of Nursing, University of Toronto, Miss S. Giroux, visitor, French Schools of Nursing, Association of Nurses of the Province of Quebec, Miss G. Hall, director of nursing, Calgary General Hospital, Miss N. MacKenzie, educational director, Montreal General Hospital, Miss R. Morrison, School of Nursing, University of British Columbia.

Panel members are kept informed, by the W.H.O. Secretariat, of activities of the organization and are expected "to take stock of the latest available knowledge and expert information and make it available to W.H.O." either periodically or on request.

Expert committees are established as the need arises "to deal with particular subject matter and consisting of a group of experts convened for the purpose..." The committee members are selected from the advisory panel but one or two additional experts may be invited to attend if the agenda warrants it.

In September 1953, the 31 panel members were notified that for the third time an Expert Nursing Committee would convene. This time the subject under consideration was to be Nursing Service Administration. This was a direct outgrowth of the previous committee meetings dealing with nursing education, the reports of which indicated the importance of efficient administration in nursing.

The announcement from Geneva was accompanied by a request that we give thought to the subject and make suggestions as to what the chief points for discussion should be, the factors which make nursing service difficult, how these difficulties should be overcome, what preparation nurses should have in administration. We were also asked if we thought the discussions should be confined to the administrative problems in nursing the sick or if those concerned with public health nursing should be included, and

Miss Morrison is an associate professor in the School of Nursing at the University of British Columbia, Vancouver.

if we believed that the committee membership should consist solely of nurses experienced in administration or if persons from other disciplines should be included. All 31 members responded with carefully thought-out replies.

The services of Mrs. Bettina Bennett, Chief Nursing Officer of the British Ministry of Labor, were secured by W.H.O. for a few months as nursing consultant for the project. Mrs. Bennett studied the panel members' submissions, conferred with many, prepared working papers and generally helped to "set the stage" for the committee meeting. In January six panel members and two non-nurse consultants received cables from Geneva which were invitations to act on the third expert nursing committee which would meet in London for a week beginning on March 29th. I was surprised and delighted to be one of them.

I left Vancouver by air on a Tuesday evening and arrived in London on Thursday morning in time for "elevenses." The flight was smooth and uneventful and London looked lovely in the early spring sunshine.

We all stayed at the same hotel off Piccadilly Circus and our meetings were held in the Ministry of Health which is close by on Regent Street. Everything had been arranged for our comfort and working convenience. One of the reasons that London was chosen as the meeting place is because Britain is in the soft currency area, thus expenses would be somewhat less than if we met in Switzerland, which is in a hard currency area.

Several organizations and key persons had intimated that they would like to entertain the committee but since only a limited amount of time could be spared from work they very wisely combined their efforts and entertained us jointly on the Sunday preceding the meetings and on a few other occasions for lunch or a late afternoon party. These social events helped us to become acquainted and to consolidate our friendships as the week progressed. They also gave us an opportunity to meet outstanding professional people in London, which was greatly appreciated. British hospitality has a warmth which is not soon forgotten!

During the first day or two of the sessions, we were ten individuals conscious of our ten personalities and jobs, and of our seven nationalities. As the time passed we quickly became a closely knit group, engrossed with a problem of common concern not only to nurses but to all the people of the world.

We all had much to learn from one another and we shared our knowledge generously. It was fascinating to see how quickly we learned to work as a total group, or in groups of two or three, as we frequently did in the afternoon or evening on special assignments.

It was fortunate that we all spoke English yet there were times when an interpreter who understood the idioms of several languages could have helped. "What do you

Members of the Third Expert Committee on Nursing.

mean by 'conference'"? "Will 'responsibility,' translated into French, have the same meaning?" "In Dutch we do not use some words in the same way as you do in English." "Do the Portugese, Chinese and Indian languages have words to correspond to these we are using?"

Miss Cockayne who was our chairman was also our official hostess at the Ministry. One might think that either duty would have been enough for an ordinary person but Miss Cockayne is no ordinary person. She handled both with consummate skill. It must have been with a sense of relief that she relinquished the chair for one session to Miss Chow, our vice-chairman. During that period it was easy to picture Chow-Mei-Yu in her role as Dean of Nursing in her homeland, Taiwan.

Miss Sleeper earned unstinted praise from all of us for the way in which she carried out a most exacting task. Surely no committee ever had a better rapporteur; her skill combined with her zealousness, patience and good humor would be hard to duplicate.

None of us will ever forget how Professor Kraus of Holland demonstrated his instinct for, as well as his knowledge of human relations. The importance of good team work and the value of the individual in the team were constantly before us in our discussions as you will see when you read the report.

Mr. Goddard's searching questions and pertinent comments about nurses and nursing made us face up to realities. From his experience with the Nuffield Provincial Hospital Trust and his industrial administrative experience, he was able to help us understand that while administration in nursing has special aspects it is fundamentally the same as in any work situation.

I am sure that Miss Doctor of India and Miss Pinheiro of Brazil would agree with me that the people whom I have mentioned particularly, together with the hard working members from the W.H.O. Secretariat, Miss Baggallay and Miss Creelman and their secretaries, did everything they possibly could to help us to study, think and work together for one rich week.

When we reviewed the final draft of the report on Saturday and signed our names on the last page we, at least, had learned a great deal. Sir John Charles, Chief Medical Officer of Great Britain, said, in essence, if the report helps the nurses of the world to evaluate their own needs, and to interpret these needs to their colleagues in allied professions, and to their respective governments the expenditure of time and money will be justified.

I have not attempted here to give a summary of the report or its recommendations but rather to tell something of its background and preparation in the hope of interesting Canadian nurses in studying and using the report for the improvement of nursing.

It is a significant fact that in countries where the practice of medicine is well advanced and the practice of nursing is not, the health status of the people shows little or no improvement. This is a challenge not only to provide nursing service and nursing education but to provide them at an administrative level that is effective.

The Donation of Good Used Hearing Aids

You may have a hearing aid lying idle in your home, or you may know of a neighbor who has one. It may meet the need of some hard of hearing person on Old Age Pension, Old Age Assistance, or the mother of a family in the low income group. Such hard of hearing persons, unable to buy a hearing aid, are referred to the National Society of the Deaf and the Hard of Hearing by departments of health, hospital clinics, and various social service agencies.

When suitable aids are made available, the officers of the Society provide an initial supply of batteries, and explain the operation of the aid so that the greatest benefit from, and proper adjustment to the aid is effected.

It is hoped that no one will allow a hearing aid to remain idle when it may be the means of bringing back into a hearing world those who may know, once more, through your generosity the happiness of "hearing." Hearing aids should be sent to: **Mr. Edward B. Lally, Managing Director, The National Society of the Deaf and the Hard of Hearing, 2 Bloor Street East, Toronto 5, Canada.**

Every minute you are angry you lose sixty seconds of happiness.

Nursing Profiles

The professional staff of the Canadian Nurses' Association has been rounded out by the appointment of **Mary Alma Rita MacIsaac** as assistant secretary. Born in Ottawa, with a Scottish and French Canadian heritage, Miss MacIsaac, as an able bilinguist, is an invaluable addition to our busy National Office.

A graduate from the University of Ottawa School of Nursing, Miss MacIsaac specialized in public health nursing. After two years with the Ottawa branch of the Victorian Order of Nurses, she transferred her activities to the Health Department there. She further qualified herself by securing her certificate in the administration and supervision of public health nursing at the University of Toronto. She resigned from the position of senior supervisor with the Ottawa Department of Health to assume her new duties in October, 1954. Miss MacIsaac is interested in reading, in plays and musicals and, whenever the opportunity is presented, loves to travel.

Van Dyck & Meyer Studios

RITA MACISAAC

Priscilla Campbell, a distinguished graduate from the Royal Victoria Hospital, Barrie, Ont., has been appointed to represent the English-speaking women of Canada on the Dominion Council of Health for the next three years. This body acts in an advisory capacity to the minister of National Health and Welfare.

Following graduation, Miss Campbell's administrative talents were clearly recognized as she progressed from night supervisor to operating room supervisor to assistant superintendent of nurses at her Alma Mater in a brief period of three years. She became superintendent of nurses at the General Hospital in Brockville, Ont., and two years later went to a similar position at the Public General Hospital, Chatham, Ont. For nearly 20 years now she has been the administrator of that hospital. Miss Campbell's capabilities for leadership have won her recognition in many directions. Not only has she held office in the Registered Nurses' Association of Ontario but she has been the president of the Ontario Hospital Association — a distinction rarely given to a nurse. She is a member of the American College of Hospital Administrators and has been Canadian representative on the Council of Public Relations of the American Hospital Association.

PRISCILLA CAMPBELL

Isabel Black has been appointed assistant director of the Division of Public Health Nursing with the Ontario Department of Health. After graduating from Victoria Hospital, London, Ont., she engaged in private and staff nursing before securing her public health nursing certificate from the University of Western Ontario. She joined the Victorian Order of Nurses and served with them in Hamilton, Orillia, and Kingston over a period of eight years then joined the provincial health service as a regional supervisor in Northern Ontario. With the

increased demand for civil defence instruction and preparation, Miss Black became nursing consultant for Ontario. She is also a member of the C.D. nursing committee of the Registered Nurses' Association of Ont.

During the years she was working in the north Miss Black developed a deep interest in the natural phenomena in the world about her. She now holds memberships in the Field Naturalist Society specializing in birds and wild flowers.

ISABEL BLACK

Eleanor Winnifred (Jamieson) Hurd joined the faculty of the McGill School for Graduate Nurses last fall as lecturer in public health nursing. Qualifying in this field immediately following her graduation from the University of Alberta Hospital, Mrs. Hurd was with the Victorian Order of Nurses for a year at Kirkland Lake, Ont., then became nurse-in-charge in the Athabasca Health Unit in Alberta. Holding her B.Sc. in nursing from the University of Alberta, her certificate in administration and supervision from McGill and her Master of Public Health from the University of Michigan, Mrs. Hurd's recent experience as director of nursing service with the Simcoe (Ont.) Health Unit has provided her with a very sound background for her work as a teacher. She participates actively in a variety of sports. Her newest interests are in the fields of geology and the culinary arts.

ELEANOR HURD

Grace E. Johnson has recently assumed the position of director of nursing and nursing education at McKellar General Hospital, Fort William, Ont. A graduate of the Winnipeg General Hospital, with her bachelor of nursing degree from the McGill School for Graduate Nurses, Miss Johnson was head nurse in the maternity department at W.G.H. until she enlisted with the R.C.A.M.C. in 1940. She served with the neurological and plastic surgery units but returned to obstetrical work following her discharge. She has been director of the maternity pavilion at W.G.H. since 1950.

GRACE JOHNSON

Katherine Diane Richardson has assumed the posts of principal of the school of nursing and director of nursing service at the Moncton Hospital, from which she graduated several years ago. A native of Sackville, N.B., Miss Richardson supplemented

her basic training by securing her certificate in teaching and supervision from the McGill School for Graduate Nurses. Prior to the assumption of her present duties she was nursing arts instructor at Moncton Hospital. She has always taken an active interest in association activities serving for a time on the Examining Board of the N.B.A.R.N. Miss Richardson is a member of the Soroptimist International of Moncton.

Beatrice Elizabeth Allen is the assistant director of nursing services at St. Boniface Hospital, Man. Born at Morden, Man., Miss Allen had received her Bachelor of Science degree in home economics from the University of Manitoba before she commenced her training at the Royal Victoria Hospital, Montreal. She enlisted with the R.C.A.M.C. in 1942 and saw active service in England and northwest Europe during World War II. Following completion of the course in teaching and supervision at the McGill School for Graduate Nurses, Miss Allen joined the teaching staff at R.V.H. In 1951 she became educational director with the Winnipeg Municipal Hospitals, relinquishing that post to assume her new duties at St. Boniface.

Pearl (Mahaffey) Prior, who graduated from the Royal Alexandra Hospital, Edmonton, in 1923, on October 30, 1954, became the second nurse to be awarded an honorary LL.D., by the University of Alberta this year. The ceremony was unique in that both Mrs. Prior and her husband received honorary degrees at the same convocation in tribute to their outstanding achievements in the mission fields in Africa.

Prior to her marriage, Mrs. Prior served as a head nurse at R.A.H. for three years. Soon after her arrival in Angola, Portuguese East Africa, she requisitioned an old warehouse to establish the Ndondi Hospital. Today, a modern hospital has replaced the makeshift structure. Mrs. Prior has lived in Nigeria for the past 16 years where she had charge of a leper colony for a time. She taught home nursing to the African girls attending the agricultural college of which her husband was founder and principal. She is the author of a textbook "Practical Nursing Procedures for African Nurses."

In Memoriam

Katherine (Porter) Cole, who graduated from Aberdeen Hospital, New Glasgow, N.S., in 1909, died in Edmonton on November 6, 1954, at the age of 69. Married in 1912, Mrs. Cole returned to active duty in 1920 when she became matron of the Peace River Hospital. She joined the Alberta Department of Public Health in 1928 and served for 21 years in various places in that province. In 1949 she accepted a post with the federal Department of Indian Affairs and worked on the Gleichen and Saddle Lake reservations.

Catherine M. Findlay, who graduated from the Winnipeg General Hospital in 1914, died in Kaleden, B.C., on July 1, 1954, following a brief illness. For some years after she graduated Miss Findlay was supervisor of the obstetrical division of the Winnipeg General Hospital.

Essie McKerracher, a native of Perth, Ont., who trained and nursed largely in the United States died in Ottawa on November 2, 1954, following a protracted illness.

Alice Maude Palmer, who graduated from the General Hospital, St. John's, Nfld., in 1918, died at Ottawa on January 2, 1954, at the age of 67, following a brief illness. For many years Miss Palmer nursed in New York City. Returning to Canada, she engaged in private nursing in Toronto and Port Hope, Ontario.

Lorraine Milanie (MacDonald) (Berge-Krogh) Patterson, who graduated from the Edmonton General Hospital in 1940, died recently in Santa Monica, Calif. She had been superintendent of nurses at the Oliver Mental Institute prior to her marriage.

Jessie Ada Peppiatt died in Vancouver on April 12, 1954, following a lengthy illness. She had been on nursing staffs in hospitals in Galt, Bowmanville, Newmarket and Port Hope, Ont.

Helen S. Peters, who graduated from The Montreal General Hospital in 1919, died in Edmonton, Alta., on November 21, 1954, after a prolonged illness, in her 60th year. Following graduation, Miss Peters served on the staff at M.G.H. She completed the course in administration at the McGill School for Graduate Nurses in 1927 and shortly after accepted the post of assistant superintendent of nurses at University of Alberta Hospital, Edmonton. She became director of nursing there in 1935.

Selina (Moore) Slonina, a graduate from St. Joseph's Hospital, Guelph, Ont., died at Toronto recently in her 51st year.

Sister St. George, a member of the Religious Hospitallers of St. Joseph, died recently at Hôtel Dieu, Cornwall, Ont., where she had been superintendent of nurses for the past 15 years.

Hilda St. Germain, a graduate of Metropolitan Hospital, London, Eng., who had worked in Canada since 1919, died at Winnipeg on November 8, 1954 at the age of 73. Mrs. St. Germain served with British forces during World War I and received honors from France and Britain. For 20 years prior to her retirement she was head of the Red Cross nursing station at East Braintree.

Eula Winifred (Ledingham) Wolfenden, R.R.C., who graduated from the Vancouver General Hospital in 1927, died on November 22, 1954, following a lengthy illness. Mrs. Wolfenden had spent many years working in the United States following graduation. She was assistant night supervisor at V.G.H. when she enlisted with the Royal Canadian Navy in 1943. Her administrative ability and experience were quickly recognized and she was appointed matron of H.M.C.S. Cornwallis, in Nova Scotia. She was Director of the Naval Nursing Branch when she was discharged from active duty in 1947.

Birth Announcement

Name: S.N.A.A.
Place: 36th Annual Convention, A.A.R.N., Edmonton,
Time: October 16, 1954
Parent: Alberta Association of Registered Nurses

The birth of the "Student Nurses' Association of Alberta" took place at the annual meeting of the Alberta Association of Registered Nurses when student representatives of the 12 schools of nursing in the province convened with the parent body.

Through the constant guidance and sustained efforts of Miss Elizabeth Farquharson and her co-workers of the A.A.R.N. Student Committee during the preceding months, the young association prepared for their official inauguration.

The Constitution and By-Laws unanimously accepted at their special session revealed the objects of the Association to be:

1. To provide a medium for the introduction of the student nurses of Alberta to the rights and privileges and the duties and responsibilities of professional nurses.
2. To vitalize the developments in nursing for the student nurses in Alberta and thus promote their greater interest in an understanding of the work of the Canadian Nurses' Association and of the federated provincial nurses' associations.
3. To promote the best interests of the student nurses of Alberta and to foster provincial unity among them.
4. To provide a means of friendly contact among student nurses throughout Alberta.
5. To assist the Alberta Association of Registered Nurses in its program of interesting young women in entering the field of nursing.

Executive members are centred in Calgary this year to facilitate the conduct of business matters. The officers are:

President: Eva S. Austin; Vice-president: A. E. Reiffenstein; Secretary: J. M. Nichols; Treasurer: S. Cootes.

The hand of support was extended from the parent organization when Miss Helen Penhale, president of the A.A.R.N., presented Miss Austin with a gavel before the general assembly. Interested eyes will now watch the growth of the Student Nurses' Association of Alberta.

"Nursing Across the Nation"

"WHAT IS GOING ON IN NURSING in Canada?" is the most frequently asked question of your National Office secretaries. This column will be an endeavor to answer that question. It will be an attempt to provide at least a bird's eye view of nurses and nursing in Canada in the space alloted to National Office in your *Journal*.

Having said that we are going to tell you "What's going on in Nursing," we promptly ask *you* to tell *us*. In a country as vast as ours, it is impossible to keep abreast of all developments. You in your own corner are doing something important in nursing. But only you, and your close associates, know and are benefiting from your knowledge and experience in nursing. Why not share it with others? Send it in to National Office that we may be able to pass it along to all nurses through this column.

The Big Move

In December your National Office moved. This was the move that had been anticipated and that was discussed and voted upon at the Biennial Meeting in Banff, June, 1954.

You may recall the recommendation presented by a group of members. They pointed out that if the C.N.A. is to accept its correct place in our national picture it should be located in our national capital.

And so, with all the provincial associations in agreement, your National Office staff set about, with a committee appointed in Ottawa, to seek suitable quarters. We found just that. We are now located right in the heart of Ottawa at **270 Laurier Avenue, West,** in the modern new Excelsior Life Insurance Building.

We are within walking distance of the Parliament Buildings, the Victorian Order of Nurses for Canada, the Department of Veterans Affairs and numerous other federal departments. We have joined the ranks of many other national organizations whose headquarters are in Ottawa.

Your National Office is now in the very favorable position of being readily available for consultation on the many developments affecting nursing in the Canadian and international spheres.

May we issue to all members of the Canadian Nurses' Association a most cordial invitation to visit your new National Office when you come to Ottawa. We, your National Office staff, will be delighted to greet you.

United We Stand

There are many ways of looking at the Canadian Nurses' Association. One useful point of view is that it represents a means to an end. The Association is not an end in itself. It is merely a means of planning for the provision of better nursing care in Canada.

When people talk about "justifying the means," they are usually referring to the most suitable means of attaining an end. A few years ago, many nurses began to feel that the organization of the C.N.A. was not the most suitable means to the general end of improving nursing throughout the nation. It was felt that some reorganization should be made. The organization of the Association into branches of nursing service tended to divide, rather than unite nurses. It was felt, for instance, that all nurses — whether institutional, private, industrial or public health — had important contributions to make to planning in nursing education and nursing service. This common planning was being thwarted by the structure of the Association. Moreover, there was

a considerable overlapping of work among the various committees.

The new committee structure of the C.N.A., approved at the last biennial meeting in Banff, is now functioning. Two months ago, the chairmen of the five national committees met in Montreal. These included the nursing education, nursing service, publicity and public relations, legislation and by-laws, and finance committees.

Of particular interest in these discussions was the subject of communications. All the chairmen felt that the new structure will only be effective to the extent that it permits a free channeling of suggestions and ideas from local chapters through provincial committees to the national committees. In this way, the national committees will obtain the benefit of thinking on such subjects as nursing service and education from nurses across the nation.

All nurses have a contribution to make to all nursing. If you are a private nurse, let it never be said of you that you have nothing to contribute. Your experience in nursing at the bedside has taught you lessons which are of use to all nurses. Other nurses may also have lessons for you. Then, too, there are important considerations in regard to the place of private nursing in the total community health program. Your participation, your suggestions, will be invaluable to your committee as it endeavors to plan in nursing education: basic, post basic, and in-service.

Nursing Service Good Example

No one need fear lest the new structure deny the importance of any one group of nurses working in a special field. On the contrary it is intended to serve the interests of all groups more effectively as the many problems common to all are shared and all work together for the good of the patient.

The new national committees will have representation from all fields of service including institutional nursing, private nursing, occupational health nursing and public health nursing. This should ensure that all groups have the opportunity to contribute to national planning.

Obviously, to provide the best possible quality of total and continuous nursing service for all people, there must be total over-all planning with close coordination and cooperation between branches of nursing service. Therefore, nurses in each area must know, understand and respect the contribution of the others in order to prevent overlapping, duplication and unmet needs.

Typical of the problems common to all nurses are the current topics of discussion of the Nursing Service Committee. Included among these are a Canadian Code of Nursing Ethics, Health Insurance, Recommended Personnel Policies and Orientation Manual. These surely concern all nurses regardless of the field in which they serve. Only by thinking and planning together can we serve the best interests of both patients and nurses.

It is hoped that the new committee structure will facilitate this understanding and cooperation in national planning.

Nursing Publicity Seen Increased

"I've noticed a great deal more publicity about nursing in the press recently," comments an Ontario nurse.

Whether or not this reflects the opinion of the average newspaper reader in this country is difficult to say. What is significant, though, is that the C.N.A. now exerts considerably more direction over nursing publicity. Prepared press releases from National Office tend to set a tone for the treatment of nursing information in newspapers across the nation. The interest of the press is channeled into nursing matters where public information is of advantage to the profession. In contrast to this, there still appears some publicity which is of little use either to the public or to the profession.

Recent months have been seen the flow from National Office of several press releases designed to promote the interests of the Canadian nursing profession. In addition, some 900 newspaper offices throughout the country have received a basic fact sheet about the nursing situation in Canada.

Indications of the type of nursing

publicity appearing in Canadian publications is revealed in the latest issue of "What They're Saying About Nursing," available from all provincial associations. It contains reproductions of representative stories about nursing which have appeared in recent newspapers.

Newspaper publicity, of course, is only one means of promoting nursing objectives. Other projects in communications are being investigated by National Office. Under serious consideration is a major film on nursing to be produced in this country. Present plans point to nation-wide distribution of the film which is expected to have wide recruitment appeal.

Also under consideration for recruitment purposes is the printing of an appealing, dignified poster for use on school notice boards and other locations where prospective nursing recruits may gather.

Attention is also being given to the development of information on psychiatric nursing about which there appears to be considerable public misunderstanding.

Back of all this activity on the part of the C.N.A. lies a basic principle which bears restatement. It is simply this: the ultimate effectiveness of nurses depends on satisfactory human relations . . . with patients, with other nurses, with doctors, hospital administrators and additional groups. Greater understanding of nursing by these groups will promote good human relations. Such understanding is only possible if people are adequately informed.

A Bilingual Asset

Recently, in chatting with an international friend who speaks several languages, we found ourselves full of admiration and envy, particularly with regard to the fluency of speech of both the French and English languages. In commenting upon this our friend replied: "Well, I was born bilingual." With a French mother and a Scottish father, the same may be said of Rita MacIsaac, new National Office assistant secretary.

Miss MacIsaac brings to National Office not only the advantages of complete bilingualism, but she possesses considerable experience at the staff, supervisory and administrative levels, in public health nursing. By sharing responsibility in the over-all program of National Office, she will enable the nursing education and nursing service secretaries to concentrate more fully on their programs.

In the Good Old Days

(*The Canadian Nurse* — JANUARY, 1915)

"The first really organized ambulance service was the work of a woman — Queen Isabella of Spain! About 1469, during the civil war being fought in Spain, she sent to the military camp tents, furniture and physicians with the express stipulation that no charges were to be made to any patient. Historians record that the 'Queen's Hospital' comprised nearly 400 wagons with awnings where the wounded were cared for by 'honest women.' These wagons were called 'ambulancias' the first use of the name which was not taken into general usage until the Crimean War."

* * *

"A vast improvement has been effected in the methods of transfusion. Some 40 years ago a surgeon conceived the idea of withdrawing fresh whole blood from a healthy donor by means of a syringe and immediately injecting the blood into the circulation of the patient before clotting could take place in the syringe. Our method is a modification of this technique. To retard clotting of the blood, all the apparatus is sterilized by boiling and lined with a coating of liquid paraffin. In the intervals between withdrawals of the blood a little warm saline is allowed to trickle through the apparatus to clear it of blood and thus prevent any clot from forming."

* * *

"The nurses in the United States are planning a 'letter day' when every member of the Association and others whose interest has been aroused will send letters of protest to magazines that carry advertisements for correspondence schools of nursing."

Le Nursing à travers le pays

Que se passe-t-il dans le domaine du Nursing au Canada? Voilà la question qui est le plus souvent demandée aux infirmières du Secrétariat national. Dans cette colonne, nous essayerons de répondre à cette question ou du moins, dans un tour d'horizon, à vous faire voir les infirmières et le Nursing au Canada.

Afin de pouvoir vous répondre sur ce qui se passe, nous allons d'abord vous demander de nous le dire. Dans un pays aussi vaste que le nôtre, il est impossible de se tenir au courant de tout le développement. Dans votre patelin, vous faites quelque chose d'important en Nursing, mais il n'y a que vous et vos compagnes de travail qui sont au courant: ces dernières bénéficient de vos connaissances et de votre expérience en Nursing, pourquoi ne pas les partager avec un plus grand nombre, si la chose est possible, nous en informerons les infirmières dans cette page.

Le grand dérangement

En décembre dernier, le Secrétariat national a été déménagé. Ce déménagement a été prévu, discuté et approuvé au congrès biennal de Banff en juin 1954. Vous vous rappelez sans doute les recommandations présentées par un groupe de membres, il était dit: que l'Association des Infirmières canadiennes se doit, par ses destinées, de s'établir dans la capitale canadienne.

Toutes les Associations provinciales étaient d'accord, notre secrétariat national, avec un comité nommé à Ottawa, se met à chercher un logis convenable, enfin nous l'avons trouvé. Voici notre nouvelle adresse, au coeur même d'Ottawa, à 270 rue Laurier, ouest, dans l'édifice de la Compagnie d'assurance "Excelsior Life."

Le secrétariat est tout près du Parlement, du Victorian Order of Nurses for Canada et du Ministère des Anciens Combattants et d'autres édifices parlementaires. Nous aurons, comme bien d'autres organisations nationales, nos quartiers généraux à Ottawa. Notre bureau est d'accès facile pour ceux qui voudront nous consulter sur les développements qui affectent le Nursing au Canada et dans les milieux internationaux.

Nous invitons cordialement tous les membres de l'Association des Infirmières canadiennes à visiter leur nouveau secrétariat national lorsqu'elles passeront à Ottawa. Le personnel du Secrétariat national sera enchanté de les recevoir.

"Tenons-nous par la main
Pour faire notre chemin"

Les opinions sont bien différentes sur ce que l'on entend par l'Association des Infirmières canadiennes. L'Association n'est pas une fin en elle-même, mais un moyen. Elle nous permet de faire des plans, de réaliser des projets qui ont comme résultat de meilleurs soins aux malades du Canada.

Il y a quelques années, des infirmières pensèrent qu'une organisation comme l'A.I.C. était le meilleur moyen d'améliorer le Nursing au pays. La formation dans l'Association de diverses sections avait pour effet de diviser les infirmières au lieu de les unir. L'on considère que toutes les infirmières — qu'elles soient des hôpitaux, du service privé, de l'industrie ou de l'hygiène publique — ont une importante contribution à faire concernant l'éducation des infirmières et le service du Nursing. Ce travail en commun se fait actuellement avec plus de facilité qu'autrefois par les nouveaux comités formés selon la nouvelle organisation de l'A.I.C. tel qu'approuvé à Banff. Il y a deux mois, les convocatrices des cinq comités nationaux suivants: éducation en nursing, service du Nursing, publicité et relation, expérience, législation et règlements et finance, se sont reunies à Montréal.

Un point d'intérêt lors des discussions fut celui des communications. Les convocatrices furent toutes du même avis, à savoir, que l'on se rendra compte des avantages de la nouvelle structure de l'A.I.C. qu'en autant qu'un libre échange d'idées et de suggestions se fera des chapitres, districts aux comités provinciaux et de là aux comités nationaux. De cette façon, les comités nationaux connaîtront l'opinion de toutes les infirmières sur les questions d'éducation et des soins.

Toutes les infirmières ont une contribution à apporter. Si vous faites du service privé, n'allez pas dire que vous n'avez rien à apporter, votre expérience au chevet du malade vous a enseigné des leçons qui seront très utiles aux autres infirmières. D'autres infirmières auront aussi des leçons qui vous

seront profitables. Il faut étudier avec soin le rôle du service privé dans le service total des soins aux malades. Votre participation, vos suggestions seront d'une grande valeur pour le comité qui s'occupe de l'éducation de l'infirmière, soit au cours de base, post-scolaire et au travail.

Le Service du Nursing

Personne ne doit craindre que la nouvelle structure diminue l'importance d'un groupe d'infirmières spécialisées, au contraire l'on se propose de s'occuper davantage des intérêts de tous les groupes, car les problèmes particuliers deviendront communs à tous, ils seront partagés par un plus grand nombre et ensemble, nous travaillerons à y trouver une heureuse solution dans l'intérêt du patient.

Les nouveaux comités nationaux seront formés, des représentantes de tous les groupes de la profession, infirmières des hôpitaux, du service privé, visiteuse et de l'hygiène publique.

Pour assurer au public la qualité et la quantité des soins qu'il requiert, une étroite coopération et une coordination entre les diverses branches du Nursing devront être observées. Les infirmières sur ces comités devront avoir une connaissance et un respect du travail accompli par l'un ou l'autre groupe, afin de prévenir les répétitions, la direction de tous les efforts dans le même sens et de laisser à l'abandon certains besoins.

Voici quelques problèmes d'intérêt général aux infirmières, lesquels sont discutés au service du Comité du Nursing, le Code d'éthique des Infirmières canadiennes, les assurances-santé, la politique concernant le personnel et un manuel d'orientation. Ce n'est qu'en pensant et en travaillant ensemble que nous pouvons servir à la fois les intérêts des malades et des infirmières.

Publicité concernant l'infirmière

"J'ai remarqué qu'il y avait plus de publicité concernant les infirmières dans les journaux," nous disait il y a quelque temps une infirmière de l'Ontario. Nous ne saurions dire si tous les lecteurs de journaux pensent comme elle, mais une chose certaine c'est que l'A.I.C. dirige plus étroitement la publicité faite dans les journaux concernant les infirmières. Des nouvelles sont envoyées aux journaux à travers le pays par l'A.I.C. L'intérêt de la presse est dirigé aussi vers les faits susceptibles d'intéresser le public tout en étant utile à la profession ; toutefois, il se fait encore dans nos journaux une publicité inutile sur certains faits, qui ont un effet nuisible.

Le Secrétariat général en plus d'envoyer plusieurs communiqués à la presse a envoyé à 900 journaux à travers le pays une feuille d'information sur la situation du Nursing au Canada.

La publicité par les journaux n'est qu'un moyen de promouvoir les buts de la profession. D'autres moyens de publicité sont à l'étude. Nous projetons la distribution d'un film à travers le pays, nous croyons qu'il aura une grande répercussion sur le recrutement.

De même, dans un but de recrutement, nous étudions la possibilité de publier des affiches, lesquelles seront distribuées dans les écoles et les pensionnats. Nous voulons aussi donner plus de renseignements concernant le nursing en psychiatrie, lequel ne semble pas bien compris.

Le principe à la base de toute la publicité faite par l'A.I.C. mérite d'être répété, c'est tout simplement ceci :

De bonnes relations entre semblables, avec les malades, les autres infirmières, les médecins, les administrateurs d'hôpitaux et les autres groupes. Une meilleure compréhension du Nursing par les autres groupes facilitera de meilleures relations. Une telle compréhension ne s'obtient que si les personnes concernées sont bien renseignées.

Bilinguisme

L'autre jour, en causant avec une amie qui a parcouru le monde et qui parle plusieurs langues, j'ai admiré et envié la facilité avec laquelle elle parlait tout particulièrement l'anglais et le français. En entendant mes compliments, cette amie me répondit "Je suis née bilingue. J'ai une mère française et un père écossais." Nous pourrions dire la même chose de Mlle Rita MacIsaac, la nouvelle assistante de la secrétaire nationale. Mlle MacIsaac, non seulement a l'avantage d'être bilingue, en plus elle a une grande expérience en hygiène publique, elle a occupé des postes dans le service général, en surveillance et en administration.

En partageant les responsabilités générales du programme de l'A.I.C., les secrétaires chargées respectivement de l'éducation et du service du Nursing pourront s'occuper davantage de leur programme particulier.

Annual Meeting in Prince Edward Island

THE 33RD ANNUAL MEETING of the Association of Nurses of Prince Edward Island was held for the first time in Montague on September 21, 1954. Total registration was 83.

The morning session was taken up mainly with association business, at which reports of committees and the two districts were given. Four of the delegates to the Biennial meeting at Banff, reported on the business conducted during the sessions, and gave a résumé of the two panels and symposium presented. Concluding the morning session a film was shown entitled "Angotee" depicting the life of a young Eskimo boy from birth to manhood.

The meeting opened officially at two o'clock with an invocation by the Rev. Donald Campbell. Greetings were extended by the Deputy Mayor of Montague and the Minister of Education.

The president, Miss Verna Darrach, concluding her second year in office, spoke of the more outstanding events from a national viewpoint. Referring to the provincial reports that had been presented, she hoped that they would cause enough discontent and stimulation to make everybody wish to dig in and increase her nursing knowledge.

The secretary-registrar reported on the year's activities of the Council; appointment of special committees; visits and talks to districts and schools of nursing; the Credential Committee and registration.

Miss Frances McQuarrie, secretary of Nursing Education, was welcomed as our guest from National Office. Her subject dealt with the new national committee structure and its implications at provincial level. She spoke of the trends in nursing education and of the need for studying how best to prepare nurses for nursing service, not only locally but internationally. She said that the teaching program should be putting more emphasis on mental nursing and on preparing the nurse to be a leader and coordinator on the nursing team. She concluded by giving an outline of the developments in National Office in the field of public relations.

The dramatization of the team work principle in nursing services "Let's Work Together" was presented and also Johnson & Johnson's film "Team Relationships in Nursing Care."

The Committee on Legislation and By-Laws presented a fairly extensive revision of the By-Laws. The principal changes were: committee structure; inclusion of associate membership; elections to and organization of the Council.

Dr. Frank MacKinnon, principal of Prince of Wales College, gave an address with the unique title "Florence Nightingale and the Maritime Economy." He drew a vivid parallel between the early life of Florence Nightingale and the struggling Maritime economies. He said that Miss Nightingale should have been called "The Lady with the Blowtorch" because of the many idiotic customs and conventions of her day which she uprooted. He stated that the Maritimes are in need of men and women of unique character and fighting spirit who will not run away from the economic problems to more lucrative parts of Canada, but will stay to confront and solve them.

The officers elected for the coming year were: President, Sister Mary Irene; vice-presidents, Miss Ruth Ross and Mrs. Vera MacDonald; honorary secretary, Miss Florence MacLean and honorary treasurer, Mrs. Mary Bradshaw.

MURIEL ARCHIBALD,
Secretary-Registrar

Annual Meeting in New Brunswick

THE 38TH ANNUAL MEETING of the New Brunswick Association of Registered Nurses was held in Edmundston on September 22-23, 1954, with a good attendance. The president, Miss Muriel Hunter, who presided at all sessions, stressed the need for every member of the association to think in terms of what is best for nursing, in the broadest sense. She also asked that all members should keep themselves informed as to what is taking place in the nursing profession, and to keep an open mind regarding changes. She referred to the retirement of Miss Alma F. Law, who had been secretary-registrar for 13 years, and to the contributions that she had made. Miss Hilda M. Bartsch had been appointed to this position on July 1, 1954.

Two committees had been especially active. The Legislation Committee submitted new by-laws to bring our standing committees

in line with those of the Canadian Nurses' Association. In addition, there is an Advisory Committee to Schools of Nursing. Because the work of the nursing school adviser had been under the supervision of this committee, and the fact that there are representatives on this committee from the Provincial Department of Health, New Brunswick Section of the Maritime Hospital Association and New Brunswick Medical Society, it seemed advisable to retain it as a standing committee.

Again this year the Educational Policy Committee has done a great deal of work in an endeavor to find a way of advancing nursing education in New Brunswick and to obtain financial support from the government or some foundation. The chairman of this committee, Miss Katherine MacLaggan, with representatives from the provincial university, the New Brunswick Medical Society, and a local hospital board formed a work committee. Early in September, this group presented a brief to the New Brunswick Department of Health and Social Services asking for the employment of a nurse-educator for a period of one year. The duties of this individual would be to study existing conditions in nursing, to submit recommendations as to the proper form of a school of nursing at the University of New Brunswick, to estimate costs of such a school, both for the University and the cooperating hospitals, and to work out other details of the project.

A guest speaker during the sessions was Miss Mildred Walker, consultant in the Occupational Health Division of the Department of National Health and Welfare. Her subject was "Publicity and Public Relations." Miss Frances McQuarrie, nursing education secretary of the Canadian Nurses' Association, spoke on her work in National Office and of some of the experiments and developments in Canadian nursing. Miss M. Grace Shannon chaired a very interesting panel discussion on "Team Nursing." There was good participation from the floor.

The annual dinner took place at the Praga Hotel. Rev. Aurele Ploudre of St. Louis University, Edmundston, was the guest speaker. His address on the "Social Aspects of Nursing" was both enlightening and encouraging. The delegates were also the guests of the Edmundston Chapter at a delightfully arranged afternoon tea.

The slate of officers is as follows: President, Miss Grace Stevens; vice-presidents, Miss Lois O. Smith and Mother Bujold; honorary-secretary, Sister MacKenzie; immediate past president, Miss Hunter.

Committee chairmen appointed at the Executive Meeting on September 23, are as follows: Nursing Education, Miss K. MacLaggan; Nursing Service, Sister Helen Marie; Publicity and Public Relations, Miss H. Jean Lynds; Legislation and By-Laws, Miss Lois O. Smith; Finance, Mother Bujold; Advisory Committee to Schools of Nursing, Miss Marion Myers; Auxiliary Nursing, Miss Muriel Hunter.

The day following the annual meeting, the instructors from the hospitals throughout the province met to discuss curriculum revision.

HILDA M. BARTSCH
Secretary-Registrar

(Continued from page 28)

chairman for this session, and participants in the panel were: Miss Alice Wright, executive secretary, Registered Nurses' Association of British Columbia; Miss M. E. Cameron, director of nurses, Winnipeg General Hospital; Miss W. M. Barratt, registrar for Licensed Practical Nurses, and Mr. Elliott Wilson, Q.C., Deputy Minister, Department of Labor, Manitoba Government. The discussion revealed that the majority of those who have studied the relationship of professional ethics to the basic sociological principles of collective bargaining believe that collective bargaining adequately conceived and creatively developed offers a means whereby nurses may speak for their professional standards and interests without ethical conflict since professional ethics are essentially a standard of behavior for the practitioners of the profession.

The annual dinner held at the Niakwa Golf Club was convened by Miss Irene Cooper. The theme, "Our Canadian Mosaic" was exemplified by the presence of new members of the association in the costumes of their homelands, and by table decorations of miniature globes and the flags of the member countries of the I.C.N. The speaker for the occasion was Mrs. Aini Mikkanen, a distinguished Finnish nurse.

LILLIAN E. PETTIGREW,
Executive Secretary

Book Reviews

Society and the Nursing Profession — an Introductory Sociology, by James M. Reinhardt, Ph.D., with contributions by Paul Meadows, Ph.D. 256 pages. McAinsh & Co., Ltd., 1251 Yonge St., Toronto 7. 1953. Price $3.50.

Reviewed by Sister Columkille, Superior, Notre Dame Hospital, North Battleford, Sask.

It is a well known fact that the educational program of the student nurse is so crowded that it does not allow enough time for all the embellishments which would certainly give to the nurse a broader and richer picture of the social life of the community at large. This is the objective of the author.

The book gives excellent reading material for the graduate nurse no matter what field of nursing she occupies. It has likewise invaluable informative material for any interested lay person. The material is concise and written in such a manner that it may be referred to easily and studied at leisure.

Chapters three, four and seven, which deal with the sociology of nursing, the sociology of the patient, and the nurse and the social worker are extremely valuable to the nurse. While she learns these principles when in training, it is of utmost importance that she re-read them, remember them, and put them into practice.

The authors have culled material and data from all parts of the world. While the book is rich in its material from the United States, it is still inadequate from an international viewpoint. The bibliography is, with few exceptions, drawn from United States. This may be quite unavoidable but it does offer a challenge to potential authors of other countries. The authors have dealt with the material in an unbiased and just way.

The book is to be highly recommended for graduate nurse reading.

Pediatrics in General Practice, by James G. Hughes, B.A., M.D. 735 pages. McGraw-Hill Co. of Canada Ltd., 253 Spadina Rd., Toronto 4. 1952. Price $17.50.

Reviewed by Elizabeth Walther, Head Nurse, Children's Ward, St. Joseph's Hospital, Victoria, B.C.

In this book the author aims "to answer the needs of busy general practitioners for a handy, concise reference in pediatrics." This he does by condensing and outlining fully the more common conditions which are found in general practice.

The first two chapters deal with the newborn and his nutrition. In the first chapter Dr. Hughes not only discusses the early care of the newborn and the premature but also the various abnormal conditions which can and do so often occur in the care of these infants. The second chapter, dealing with infant nutrition, is very concise but detailed. The author has combined academic pediatric experience with reality.

A whole chapter is confined to the problems of fluid and electrolyte balance. In the author's words "the ultimate aim of diagnosis, the rational basis of therapy, is an understanding of pathological physiology."

From chapters 5-12, Dr. Hughes discusses the more common conditions found in children such as diarrhea, acute and chronic infections of the respiratory tract, the urinary tract, routine immunizations, the blood and the cardiovascular systems.

The last few chapters deal with the emotional and psychological aspects of infancy and childhood, with a chapter on allergic diseases which "the general practitioner will encounter whether he likes the subject or not."

Although written primarily for the medical profession, this book will be of interest to all graduates engaged in pediatric nursing.

After a life of hard work many old people, particularly invalids, suffer from their forced inactivity. In Sweden, this problem has attracted Red Cross attention. Some 1,200 volunteers and 500 occupational therapy experts now visit the old and lonely, particularly chronic invalids, and endeavour to bring new interest to their lives. Outings, group meetings and car drives are organized by the Red Cross to keep the old folk in contact with the outside world. Simple handicrafts, such as weaving and knitting, are taught in 600 local sections with astonishingly happy results. The old, even those bedridden, realize they can still be useful and take pride in personal achievements, the best stimulant towards health and cheerfulness.

Student Nurses

My Impression of Geriatric Nursing

RETA ALLAN

GERIATRICS IS USUALLY DEFINED as that department of medicine which is concerned with the disease of old age. I like to think of geriatrics as the branch of medicine that is concerned, not only with diseases of this group, but also with keeping older people happy and in good health.

The nurse who is to be successful in this work must have a genuine liking for old people. She must not just tolerate them because she needs the position. These frail, old individuals usually need to be liked as much if not more than they need to be nursed. The nurse must believe that these people have ability to do much more than just breathe and stay alive.

The number of older people is increasing every year. Consequently, in order to overcome this problem of too many long-term patients and not enough nurses, we must find some way for them to help themselves or better still support themselves.

If we teach a patient to do something helpful, or make something that will, at the same time give him satisfaction, he will probably work at it with much more enthusiasm than a younger person. It gives him encouragement, makes him think that he is useful and life is still worth living, rather than that he is just a burden on someone else and the sooner he is gone the better.

The nurse must also have patience — the never-ending kind that can survive no matter how many demands are made, or how unimportant and small they are. We must remember that these apparently inconsequential services probably make the difference between comfort and discomfort for the patient who cannot perform them himself.

Miss Allan is a student at the General Hospital, Stratford, Ontario.

Nursing old people is just as hard and exacting as nursing individuals of other ages. But because so many old people suffer from chronic diseases, there is a tendency among some nurses to neglect today what can be done tomorrow. The patient's ailments will be the same tomorrow so why worry too much? Under these conditions it is difficult to maintain the alertness and enthusiasm necessary for good nursing. The actual physical work is usually greater because these people, as bed patients, require more service than younger patients do. Those out of bed cannot care for themselves as completely or as well as the younger patients who can be up.

The atmosphere should be more like that of a home than a hospital. These people want their personal possessions around them, and they also have personal habits they won't change. To avoid upsetting hospital routine and procedure too much it is often not possible for each patient to have many of his personal belongings scattered about. His particular habits and customs may not be accepted with much pleasure. Severe efficiency and professionalism are not appreciated by elderly people. They will turn to those who talk to them as personal friends rather than to a person who handles every matter strictly in a business-like way. They like to feel on equal terms with their associates.

Nursing geriatric patients does not need to be considered a palliative or comforting service any longer. With new methods of occupational therapy, physiotherapy, etc. being discovered, many persons thought to be chronically ill and disabled are being treated and discharged, able to look forward to a good many happy and useful years. Therefore, nurses in this department, if they are interested and willing, will

find much to learn if they are to keep up with these new discoveries. The going is slow, but great efforts are being made to make old age a happier time of life than it has been up to the present.

In conclusion, geriatric nursing is certainly not the service for a nurse who wants to take life easy. More and more nurses and assistants are going to be needed as new methods of treatment for many chronic illnesses are discovered. We are all going to be old some day, and so if we "pitch in" now and help in carrying out these new trends in treatment and rehabilitation — who knows — maybe we will be the ones to reap the benefits!

Alberta

The following are staff changes in the Alberta Division of Public Health Nursing:

Appointments — *Mrs. G. Signe Genoud* (Calgary Gen. Hosp.) to Plamondon; *Mrs. Marolin (Hebert) Dahl* (University of Alberta Hosp.) to New Brigden; *Dorothy Vinge* (Royal Alexandra Hosp.) to Blueberry Mountain.

Leave of Absence — To take the public health nursing course at University of Alberta: *Brigitte Baumgardt* from Grassland, *Louise Schepers* from Fort Assiniboine; *Ursula Wiesbach* from Blueberry Mountain. *Elaine Cornish form Bonanza*, taking the public health nursing course at McGill University; *Mrs. Herron* from New Brigden; *Edith Robinson* from Kinuso to take a holiday in England.

Returned to Staff — *Mrs. Pearl (Mills) Fletcher* to do part-time in Bonanza district;

Mrs. Jean K. Longson to Fort Assiniboine; *Marjorie Mitchell* to Kinuso after a year's leave of absence, part of which was spent in study at Baker Sanatorium.

Ontario

The following are staff changes in the Ontario Public Health Nursing Services:

Appointments — As supervisor, *Ina Dickie* (Hamilton Gen. Hosp., University of Western Ontario certificate course and University of Toronto advanced course in administration and supervision) to Simcoe County health unit; as senior nurse, *Frances Jolliffe* (H.G.H. and U. of T.) to Wellington County health unit. *Margaret Hunter* (St. Michael's Hosp., Toronto, and University of Ottawa cert. course) to Sudbury board of health; *Willa McCaffray* (St. Mich. H., Toronto, and McGill University) to Timiskaming health unit; *Daisy Munnings,* formerly with Hamilton Dept. of Health, to Wentworth County school health service; *Audrey (Pennell) Reeve* (Wellesley Hosp., Toronto, and U. of T. general course) to Welland and District health unit; *Julia (Bristow) Roberts,* formerly with Leeds and Grenville health unit, to Northumberland and Durham health unit.

Resignations — *Heather McDonald,* as supervisor, and *Edith McQuat,* staff nurse, from Muskoka District health unit; *Ilean (Gibson) Hawkin* and *Marilyn Riches* from Peel County health unit; *Edith Munroe* from Kingston board of health; *Ena Powell* from Stratford board of health; *Irene Weirs* from Hanover board of health.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — Belleville: *Therese Callaghan* (Hôtel Dieu Hosp., Kingston). Burnaby, B.C.: *Mrs. Ethel MacLeod* (Holy Cross Hosp., Calgary). Edmonton: *Margaret MacManus* (Edmonton Gen. Hosp.). Guelph: *Mrs. Gladys Fenwick* (Toronto Gen. Hosp.). Hamilton: *Joan Taylor* (Hosp. for Sick Children, Toronto). Kingston: *Carolyn Henderson* (Saint John Gen. Hosp., N.B.).

London: *Pauline McCankey* (Victoria Hosp., London). Medicine Hat: *Joan Jones* (Toronto West. Hosp.). Montreal: *Mrs. Alice Caplin* (Hosp. for S.C., Toronto), *Maisie Cuffe* (Kingston Hosp., Jamaica), *Bertha Hoffman* (St. Paul's Hosp., Saskatoon), *Ann Johnson* (Montreal Gen. Hosp.), and *Mrs. Audrey Smith* (Sherbrooke Hosp., Que.). Ottawa: *Dosse Cleary* (Royal Victoria Hosp. Montreal), *Jean Couture* (University of Ottawa, Ont.). Regina: *Mrs. Shelagh Tulloch* (Winnipeg Gen. Hosp.). Toronto: *Joan Brown* and *Jean Corner,* (both T.G.H.), *Elizabeth Beeby* (Women's College Hosp., Toronto), *Margaret Curran* (Ontario Hosp., Brockville), *Esther Koponen* and *Isabel Sidey* (both Wellesley Hosp., Toronto), *Daphne Robertson* (Vancouver Gen. Hosp.). Vancouver: *Phyllis Christian* (College of Med. Evangelist, Los Angeles), *Marlene Dutton* (St. Paul's Hosp., Vancouver), *Helen Mary Hope* (Trudeau San., Saranac Lake, N.Y.), *Irene McConnell* and *Averil Peterson* (both V.G.H.), *Marjorie Snowden* (W.H., Toronto). Winnipeg: *Enid Calder* (Royal Victoria Hosp., Montreal), and *Brenda Gauer* (W.G.H.).

Transfers — From staff to nurse-in-charge: *Margaret Bath,* Medicine Hat; *Nancy Code* from Kingston to Gananoque; *Therese Kelly* from Vancouver to Niagara Falls; *Rebecca Mackley* from Truro to Bridgewater. As nurse-in-charge: *Goldie Duncanson* from Medicine Hat to Sault Ste. Marie. *Patricia Corbett,* from nurse-in-charge, Lake of Two Mountains to staff, Vancouver.

Nursing Sister's Association

A number of the members of the *Montreal Unit* attended the service at the Cenotaph on Remembrance Day when Mrs. Bisaillon placed a wreath. Later, the annual dinner, attended by 80 sisters, was held in the Windsor Hotel. Among the guests were: The guest speaker, Major-General E. G. Weeks, C.B.E., Mrs. Weeks, three nurses attending McGill University, and a member of the Windsor Unit. An interesting feature of the program was a roll call. It was noted that two members had served in both World Wars, a number in World War I, while those in World War II represented the navy, army, air force, and SAMNS.

The annual dinner meeting of the *Prince Edward Island Unit* was held at the Charlottetown Hotel on November 11 with 13 members present. A business meeting followed when new officers were elected: President, V. Darrach; vice-president, Mrs. B. Brown; secretary-treasurer, H. MacLaine. Plans for a Christmas treat for some of the inmates of Beach Grove were made. A social hour followed.

Fifty members were present at the annual meeting and tea of the *Victoria Unit* at the Y.W.C.A. on Remembrance Day. The following officers were elected: President, M. Graham; vice-presidents, Mmes Smith, Stillbourne; secretary-treasurer, M. Burnes; representative to the press, O. Watherston. After tea, boxes of cakes and sandwiches were taken to shut-ins and flowers to hospital patients. In the morning Mrs. Crofton, World War I holder of the Military Medal, Croix de Guerre and Serbian Gold Medal, placed the wreath at the Cenotaph. Attending with the members was Mrs. M. MacLennan, Boer War veteran, who, as probationer at St. Thomas's Hospital in 1898, saw Miss Nightingale perform her last office of awarding graduation pins.

Institute in Nova Scotia

The School of Nursing, Dalhousie University announces a three-day Institute to be held on February 16, 17, 18, 1955, at the University. There will be a registration fee of one dollar.

The Institute will be on nursing aspects in the care of the maternity patient and the new-born with emphasis on natural childbirth teaching and neonatal care. Discussion on ante- and post-natal teaching at clinics and in the home, films and other visual aid material will be utilized. The program is designed for public health nurses as well as for institutional and private nurses caring for maternity patients.

The conference leader will be Miss Aileen Hogan, a member of the staff of the Maternity Center Association, New York City. Our guest will be ably supported by Dr. H. B. Atlee and the staff of the obstetrical department of the University.

E. A. Electa MacLennan
Director

News Notes

ALBERTA

District 3

Calgary

The annual meeting of the district was attended by 34 members, including four student nurses. It was decided to have a bursary fund to help students complete their entrance into the two schools of nursing. A committee was appointed for the tea planned. The voting delegates, A. Fallis and D. Grad, gave reports on the C.N.A. Biennial Convention in Banff. Miss Austin, president of the Student Nurses' Organization, spoke on the aims of the organization; the executive was also present. The guest speaker was Mrs. Tone, social worker with the Alcoholism Foundation of Alberta, who gave an interesting account of the functions of the Foundation and the role played by the nurse.

Vulcan

A fall meeting of the chapter under the chairmanship of Mrs. G. Graham in the absence of Mrs. McIntyre was attended by 11 members. It was decided that a new project — supplying books for the hospital — be started. At an earlier meeting, there were 9 members present and plans were made for a party. Cards of thanks from E. Hyslip and Mrs. J. Marshall were read.

District 5

Hanna

At the October meeting of the district there were 10 members present and Mrs. Pennock who attended the provincial convention in Edmonton with Mrs. White, gave an account of the highlights of that occasion. It was decided to send Mrs. Pennock as delegate to Hanna Hospital board meetings so that topics and problems regarding nursing may be brought to the association's attention.

District 7

Edmonton

At a regular meeting of the district recently, conducted by R. Ball, there were 30 members present. It was decided to attend the annual district meeting the next month in lieu of the regular meeting. Following the completion of business, Mr. B. White of Imperial Oil Ltd. presented a film.

Jasper

Eight members attended a regular meeting of the Edith Cavell Chapter held at the home of Mrs. Hogan in the fall. During the election of officers, Mrs. McCague was made president by an unanimous vote and M. Barry, secretary, by acclamation. Plans were made to contact the Tuberculosis Association concerning x-ray units in Jasper when available.

Stony Plain

Twelve members and two guests attended a recent regular meeting of the chapter and heard the report of M. Story, delegate to the annual provincial meeting in Edmonton. Seven films suitable for presentation at future meetings were chosen from a list submitted. A lively discussion followed the address of the guest speaker, Mrs. W. Norquay, nurse consultant for the Alberta Tuberculosis Association.

An earlier meeting was attended by 15 members when the guest speaker, Mrs. J. Oliver, district secretary of the Canadian

Cancer Society, outlined in detail what the society does for its patients. Mrs. Stevenson accompanied Mrs. Oliver and introduced her, explaining how the funds raised annually in the cancer campaign are used. Three films, two on cancer and a third in a lighter vein, were shown. A vote of thanks was given to Mrs. Oliver.

BRITISH COLUMBIA

CHILLIWACK

The first fall meeting took the form of a well attended dinner. Mrs. A. Edmeston presided. Miss A. Wright, executive secretary and registrar of the R.N.A.B.C., guest speaker, gave an illustrated talk on her trip as delegate to the I.C.N. in Brazil. Miss L. Richardson of a local florist shop demonstrated interesting floral arrangements at the November meeting. Plans were made to hold the December meeting at Coqualeetza Hospital and to take the special guests, the Future Nurses' Clubs of Chilliwack High School, on a tour of the hospital at that time. Members attended the Fraser Valley district meeting in Abbotsford and the Provincial Nursing Exposition in Vancouver.

Letters of appreciation were received from two bursary winners, G. Carlyon and M. Read. Bursary funds were augmented by individual contributions and the sale of raffle tickets on a Lazy-Bone chair. $10 was donated to CARE and $60 to Save the Children fund. A contribution was made towards the furnishing of the new R.N.A.B.C. offices in Vancouver. Members are assisting Mrs. F. Barwell, instructor of the weekly First Aid classes, given by the Red Cross.

VANCOUVER

St. Paul's Hospital

Several out-of-town members of the alumnae association attended the Homecoming gathering held in the fall under the convenership of Mrs. de LaSalle. It has been announced that all back fees for members have been cancelled and active members will pay only the current $2.00 fee. Last year, donations of $25 each were made to: Polio fund, Milk for Korea, Red Cross, Community Chest and Cancer fund.

B. Brooks has joined the staff of Sick Children's hospital, Toronto, and Mrs. Innes Browne of Penticton is attending University of British Columbia. Mrs. M. (Audet) Guiry was a recent visitor and plans to move to Walla Walla, Washington.

MANITOBA

DAUPHIN

Registered Nurses' Association

The regular monthly meeting of the association was held at the home of Mrs. K. Little when 14 members were present. It was noted from the treasurer's report, given by Mrs. J. Blackburn, that $74 was collected at the rummage sale held in November.

Plans for the Christmas party were made.

FLIN FLON

Graduate Nurses' Association

An amendment to the by-laws passed at a fall meeting provided for future annual meetings and election of officers to be held in January of each year. Members enrolled during the year totalled 60 with an average attendance of 30.

Projects financed by funds obtained through membership fees, the Sunshine fund, and annual Charity Ball include the following: Donations to social welfare. Retarded Children's Association, Korea fund, March of Dimes, Red Cross, Kinsmen's Club for crippled children, and the Salvation Army Red Shield appeal. Members assisted at Red Cross and tuberculosis x-ray clinics. The Cancer tag day and Channing Brownie Christmas party were sponsored.

The April meeting took the form of a dinner meeting in honor of Miss L. Pettigrew; later Miss Pettigrew spoke on the work of the M.A.R.N. Other speakers during the year were: on tuberculosis, Dr. Forrester of Brandon, an illustrated talk, and Janet Smith, public health nurse, at another meeting showed films; on polio, Mrs. Sanford, with the report of her trip to Winnipeg and Miss Cook, at a later meeting. Constable Donnan of the R.C.M.P. spoke on the life of the Eskimo and Miss Cook of the Cancer Research Institute gave an interesting account of that work and showed films.

WINNIPEG

General Hospital

At a recent meeting of the alumnae association, $300 each was voted to assist two graduates of the school of nursing to take post-graduate studies. Following the business meeting, Mrs. H. J. Merkeley gave an illustrated talk on her trip to her homeland, South Africa.

Officers elected at the annual meeting were: Honorary president, Mrs. J. Morrison; president, J. Whiteford; vice-presidents, Mmes G. Kent, J. Ridge, W. McKeag; recording secretary, Mrs. K. McFerran; corresponding secretary, Mrs. J. McNamara; treasurer, Mrs. M. McKay. Among others assisting in various capacities is Mrs. E. English as representative to *The Canadian Nurse*. A social hour and refreshments followed the close of the meeting.

NEW BRUNSWICK

CHATHAM

Mount St. Joseph Hospital

A ceremony of interest to many was held in October at the hospital when eight practical nurses received their caps. Participants were: A. MacDonald, M. Currie, V. Nash, C. Connolly, M. Warnock, Mmes S. Wood,

L. Traer, J. MacMillan. A social hour and refreshments followed the ceremony.

EDMUNDSTON

The 123 members who attended the annual provincial meeting of the N.B.A.R.N. here were guests of the chapter at a tea in the city hall and the executive members at a dinner prior to the general sessions meetings. Rev. A. Plourde, guest speaker, chose the topic, "Social Science," while Rev. N. Pichette gave the invocation and Mayor H. E. Harmen welcomed the members.

At a regular meeting of the chapter on a later date, Miss V. LaRose, assistant commissioner of the N.B. division of the Canadian Red Cross Society, as guest speaker, spoke on Civil Defence.

MONCTON

Hospital Nurses' Aid

The president, Mrs. J. Innes, conducted a meeting held in the nurses' home at Moncton Hospital recently. Mrs. K. Carroll reported on the progress of the bookmarks. Plans were made for a rummage sale, a Christmas party and the donation of a sum of money to the hospital for the purchase of Christmas gifts for needy patients. Refreshments were served by: K. Richardson, Mmes H. Henderson, L. Munn, and N. Smith.

NEWCASTLE

Sr. Skidd, president, conducted the October meeting of Miramichi Chapter and read an account of the annual provincial meeting in Edmundston that she attended as delegate while Sr. MacKenzie read the address given at the banquet. Misses Loggie and Martin who attended the C.N.A. Biennial Convention in Banff gave some highlights of their visit. Under the convenership of Mrs. Jarvis and Miss MacKenzie games were played and refreshments followed.

In the absence of Sr. Skidd, the president, Miss Lynds presided at the November meeting of Miramichi Chapter. There was a fairly good attendance and chairmen and personnel of new committees appointed to establish more uniformity with the provincial association were selected. It was agreed that each member would bring to the December meeting a gift suitable for a child. To aid in stimulating interest in the meetings, it was suggested that each member bring a new idea concerning the program to the next meeting.

Miss Martin who attended the C.N.A. Biennial Convention in Banff showed interesting films of her trip. Dr. J. A. MacMillan gave a splendid address on leukemia and its treatment.

NOVA SCOTIA

DARTMOUTH

Nova Scotia Hospital

A three-day reunion in September, sponsored by the alumnae association, marked the 60th anniversary of the first graduating class of the school of nursing. The program opened with registration of members and a tea in the nurses' lounge when a suitably engraved silver tea service was presented by Mrs. A. MacArthur on behalf of the alumnae to Miss Eleanor C. Purdy, director of nurses. The next day graduating exercises for the class of 1954 were held followed by the graduation ball in the evening. Members of the alumnae toured the hospital on the third day prior to a buffet luncheon and in the evening drove to Wolfville where a reunion dinner was held at the Paramount Hotel.

Mrs. Irene Tullock of Milton, Mass., medallist of the class of 1900, was an honored guest.

YARMOUTH

Yarmouth Hospital

Miss May McBean, former nursing instructor at Payzant Memorial Hospital, Windsor, N.S., has been appointed director of nursing education. Following graduation from Mile End Hospital, London, Eng., Miss McBean took post-graduate training in isolation techniques and maternity at North Western Hospital, Hampstead, Eng. Coming to Canada in 1948, she was supervisor of the

medical, surgical and pediatric unit of Norfolk General Hospital, Simcoe, Ont., until 1951 when she entered Dalhousie University to obtain her teaching certificate.

ONTARIO

DISTRICT 1

WINDSOR

Riverview Hospital

Miss Mabel Hoy was appointed to succeed Miss Mary Shand as director of nursing. A graduate of Sarnia General Hospital, with post-graduate work in public health nursing at the University of Western Ontario and studies in nursing at the University of Michigan, Miss Hoy was for several years field contact worker for the Essex County Sanatorium as social service nurse with the Essex Health Association. From 1945 to 1953 she was director of public health nursing for Windsor board of health and left that post to become social service worker at Riverview Hospital during the past year.

An advisory member of Windsor and Essex County Chapter and representative of nurses on the senate at Assumption College, Miss Hoy also serves on the senior citizens' committee of the Community Welfare Council and is a member of the Goodfellows and Zonta Club.

DISTRICT 5

TORONTO

General Hospital

The following are some of the activities and projects of the alumnae association during the past year, contained in the recent annual report of the president, E. Stuart: $351 was used through trust funds to help nurses; the membership totalled 1,100; Ethel Irwin, Class '44, received the Mary Agnes Snively Bursary and took the advanced course in public health nursing; the Coronation Tea netted $174.78 and Theatre Night, $334; the fund for Aid to Flood Victims of Britain was given $150 through the Red Cross; the hospital social service Christmas fund received $100; and a cheque for $2,452 was presented to the T.G.H. building fund.

The Year Book may be obtained from Gwen Prout at T.G.H. at a cost of $2.50. Much credit is due those who made this project possible.

E. Robson, director of nursing at Victoria Hospital, London, was chairman at a dinner celebrating the 25th anniversary of the class of '29. On behalf of the class, R. Couse presented the president of the alumnae association, E. Stuart, with a gavel in recognition of the association's Diamond Jubilee this year.

Miss Stuart has been made associate professor of hospital administration at University of Toronto. M. Montgomery, on private duty locally since her return from Boston, plans to go to Vancouver. M. McTaggart is doing general duty at Chapell Hill Hospital in North Carolina. A. Thibodeau is ward instructor in surgical nursing at Oshawa General Hospital.

TORONTO

Women's College Hospital

On behalf of the alumnae association, Mrs. (Spademan) Hood made a presentation to Mr. Stainton who retired after many years' association with the hospital. M. Miller is now assistant supervisor. Mrs. (Leggett) Kempling and her husband are teaching at the United Church day school on the Indian Reserve at Christian Island, Ont. E. Reed has been posted to Singapore with the R.A.F. while Mrs. (Joy) Haeling has gone to Hawaii for two years. V. Allen is church visitor in Edmonton; M. Won is working at Sunnybrook Hospital; and H. Snider with handicapped children at the Red Cross.

DISTRICT 8

CARLETON PLACE

Carleton Place and District Memorial Hospital

Cora E. Drappo of Chesterville, Ont., has been appointed superintendent of the hospital. Included in her extensive nursing experience are such posts as: Assistant superintendent of Cornwall and Galt General Hospitals, becoming superintendent of the latter and later

holding the superintendency at Cobourg General and Trenton Memorial Hospitals.

District 10

Dryden

District and General Hospital

Miss Dorothy Rorke, former administrator and supervisor of nursing at Sioux Lookout General Hospital, is the new supervisor of nursing following the resignation of Mrs. Peter Stewart who has been acting supervisor for the past three years. Miss Rorke assumed her new position on November 1.

District 12

New Liskeard

The Tri-Town Chapter, R.N.A.O., meeting was opened by the chairman, Miss B. McKay. Plans were made for a Snowball Dance in January, with D. McKinnon as convener of her own committee. Three interesting and entertaining films were shown after which a delicious lunch was served. M. Glazier is now on the staff of the Sick Children's Hospital in Toronto, and B. Bagshaw is with the Misericordia Hospital in Haileybury, Ont.

PRINCE EDWARD ISLAND

Charlottetown

R. Ross, president, presided at a recent district meeting when approximately 40 members were present. Committees were appointed to make a thorough revision of the By-Laws to be presented at the next meeting and to organize a refresher course to be given in the new year. The program included a role-playing presentation on internal communications and a discussion on educational requirements of applicants to schools of nursing as well as the interpretation of registration and license as outlined by the Nurses' Act. Some members of the Little Theatre Guild presented the play, "Scattered Showers," depicting how children reflect attitude and behavior of parents. Buzz sessions and a lively discussion on the play and how points emphasized could be applied to nursing followed.

Prince Edward Island Hospital

Mrs. W. Shaw presided at the annual meeting of the alumnae association when the following officers were elected: President, Mrs. K. MacKinnon; vice-president, Mrs. W. MacEachern; secretary, F. MacLean; treasurer, A. Jenkins. Others serving are: B. Tweedy, M. Hardy, H. MacLaine, and S. Stearns. Plans for a pantry sale were discussed.

QUEBEC

Montreal

Royal Victoria Hospital

Officers of Vancouver Chapter elected recently are: President, E. (Williams) Fleming; vice-president, K. (Wallace) Young; secretary-treasurer, B. (Graham) Freeze; social convener, H. (Spear) Dun. B. (Bissett) White was elected president and C. (Schofield) Fowler, secretary, of Saint John (N.B.) Chapter.

Lieut. Comm. M. Nesbitt has been appointed matron-in-chief of the nursing service, R.C.N. E. Wade is record librarian of St. Michael's General Hospital, Lethbridge, Alta. M. (Ross) MacLeod, New Glasgow, N.S., attended the Disaster Control course held at Arnprior. R. Drury, F. Strachan, M. Angus, J. Henderson, and E. Mills have joined the staff of Moncton General Hospital while C. Hodge, D. MacLean, and P. Raymond have joined that of Ridgewood Hospital, New Jersey.

M. Matheson is a member of the R.N. Examining Board for Nova Scotia. M. Moxley was guest of honor at a tea recently prior to her departure from staff. Recent visitors to hospital were: P. (Dowie) Carleton, P. Raymond, and J. (Montgomery) Burn.

SASKATCHEWAN

Saskatoon

St. Paul's Hospital

Sister D. Lefebvre, dean of Marguerite d'Youville College, was a recent visitor. The students' retreat was conducted by Father Wadey of Regina. A regretful farewell was bade Mrs. Wyer, librarian for the past six years. Plans were made to have the Glee Club, directed by Mr. B. Duigan, take part in the St. Cecilia concert. Active committees formed by the professional nursing personnel bring to general staff meetings lively topics of discussion.

Positions Vacant

ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
U.S.A. & Foreign — *$7.50 for 3 lines or less; $1.50 for each additional line.*

Closing date for copy: 20th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

Assistant Director of Nursing Service and Education, qualified, for 350-bed hospital. Personnel policies based on R.N.A.O. recommendations. For further details apply Director of Nursing Education and Nursing Service, General Hospital, Port Arthur, Ont.

Head Nurse for Surgical Floor, also **Graduate Nurses for general staff duty in Paediatrics, Medical and Surgical, Emergency,** immediately. Excellent working conditions; no split shifts; 44-hr. week; additional premium for 3:00 p.m. — 11:00 p.m. shift. Apply, giving past experience and references, to **Director of Nursing Services,** South Waterloo Memorial Hospital, Galt, Ont.

Supt. of Nurses required for Newfoundland Provincial Department of Health Hospital for Mental and Nervous Diseases. The occupant of this post is responsible for the nursing program, particularly the female dept. There is a yearly training program for nursing assistants and an affiliating training program with other hospitals for registered nurses. Applicants should possess psychiatric and administrative training as well as previous experience. Salary is on the scale $3300-100-3500 per annum. Board and lodgings are available in modern nurses' home for $50 monthly, deductible from salary, and uniforms and laundry services are provided. Passage will be paid to St. John's. Applications, including qualifications and experience, should be addressed to; C. H. Pottle, M.D., Superintendent, Hospital for Mental and Nervous Diseases, St. John's, Newfoundland, Canada.

Head Instructor for Training School to teach Sciences. 86-bed hospital; 30 students. Complete maintenance provided in comfortable suite. Apply, stating qualifications & salary expected, A. J. Schmiedl, Sec.-Manager, General Hospital, Dauphin, Man.

Obstetrical Supervisor for 70-bed General Hospital. Salary: $200 per mo. & up, depending on qualifications. Good personnel policies. Apply Supt., Ross Memorial Hospital, Lindsay, Ontario.

General Supervisors, Charge Nurses & General Duty Nurses for new 150-bed hospital. Starting salary for General Duty Nurses — $220 for B.C. Registered, with annual increases up to $30. 40-hr. wk. 1½ days cumulative sick leave. 28 days vacation. 11 statutory holidays. Apply Supt. of Nurses, Trail-Tadanac Hospital, Trail, B.C.

Occupational Therapist (female) for 900-bed hospital. The duties of this post consist of taking charge of occupational therapy in the female department which has a modern central occupational therapy dept. that gives supervision to ward occupational therapy, and operates in liaison with the dept. of recreational therapy. Applicants should have specific training in occupational therapy and preference will be given to those whose training has oriented them in the field of psychiatry. Salary is on the scale: $2800-100-3000 per annum; board and lodgings are available in modern Nurses' home for $40.00 monthly, deductible from salary, and uniforms and laundry services are provided. Passage will be paid to St. John's. Applications, including qualifications and experience, should be addressed to: C. H. Pottle, M.D., Supt., Hospital for Mental and Nervous Diseases, St. John's, Newfoundland, Canada.

Instructors for: Science Teaching followed by Clinical Ward Teaching; Clinical Ward Teaching & lectures in Medical Nursing. Commencing salary: $250 (additional for experience). Current R.N.A.B.C. contract in effect. 65 students; one class per yr. For information about position & community apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Science Instructor; Operating Room Supervisor — experienced, preferably with postgraduate course — and **Charge Nurse** for new 100-bed hospital. Salaries open. Apply Supt., Charlotte County Hospital, St. Stephen, N.B.

HOSPITAL NURSES

GRADE 1 — $2,430-$2,820 GRADE 2 — $2,730-$3,120

Department of Veterans Affairs Hospitals

Camp Hill, Halifax	Deer Lodge, Winnipeg
Ste. Anne's, Montreal	Veterans Hospital, Saskatoon
Sunnybrook, Toronto	Colonel Belcher, Calgary
Westminster, London	Shaughnessy, Vancouver

Application forms, available at your nearest Civil Service Commission Office, National Employment Office or Post Office, should be filed with ***The Civil Service Commission, Ottawa.***

CIVIL SERVICE OF CANADA

Night Supervisor, Head Nurses & General Duty Nurses for 147-bed Medical & Surgical Sanatorium. Salary dependent upon experience & qualifications. Residence accommodation if desired; transportation arrangements for those living out; 1 mo. vacation annually, sick benefits, etc.; time allowed for university study. For full particulars, apply Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal 5, Quebec.

Instructor for School of Nursing. Applications are invited for this position at King Edward VII Memorial Hospital — 138 beds — affiliated with Montreal hospitals. This school is affiliated with teaching schools associated with McGill University, Montreal. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

Operating Room Nurse (experienced, preferably with post-graduate course); **Operating Room Staff Nurses.** Opportunity for advancement. Full maintenance. Travel allowance. For full particulars, write Matron, King Edward VII Memorial Hospital, Bermuda, giving particulars & date available.

Public Health Nurse — Grade I — British Columbia Civil Service, Dept. of Health & Welfare. Starting salary: $255-260-266 per mo., depending on experience, rising to $298. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in B.C. & have completed University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of province.) Cars are provided; 5-day wk. in most districts; uniform allowance. Candidates must be British subjects, under 40 yrs. of age, except in case of ex-service women who are given preference. Further information may be obtained from Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C. Application forms obtainable from all Govt. agencies, Civil Service Commission, Weiler Bldg., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Victoria, B.C.

Public Health Nurses for generalized program in rural-suburban Health Unit near Toronto. Minimum salary: $3,000; pension plan. For full details apply Supervisor, Peel County Health Unit, Court House, Brampton, Ont.

Operating Room & General Staff Nurses for 155-bed Acute General Hospital, located in famed San Joaquin Valley. Starting salary: $275 per mo. — $10 monthly differential in surgery; regularly scheduled increases; 40-hr., 5-day wk; 2 wks. paid vacation after 1st yr.; 3 wks. after 3 yrs.; 1 mo. after 5 yrs; travel expenses refunded after 1 yr. employment. Write Administrator, Community Hospital, 1234 "S" St., Fresno 1, California.

Operating Room Nurses. An interesting variety of experience is available to operating room nurses at the Montreal General Hospital. For further information, apply Director of Nursing, General Hospital, 60 Dorchester St. E., Montreal 18, Que.

Charge and General Duty Nurses for 80-bed general hospital. Good personnel policies. Apply Director of Nursing, Parry Sound General Hospital, Parry Sound, Ontario.

School of Nursing, Metropolitan General Hospital

WINDSOR, ONTARIO

Positions open: **CLINICAL INSTRUCTOR IN SURGICAL NURSING**
HEALTH INSTRUCTOR

This is a new school taking in 32 students once yearly, with opportunity for the faculty to participate in the development of the curriculum upon sound educational lines.

For further information apply to:

Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario.

General Duty, Operating Room & Obstetrical Nurses. Salary: $200 for recent graduates Laundry. 8-hr. day, 44-hr. wk. — straight shift. $20 differential evenings — $15 nights. Vacation, sick time, statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Director of Nursing, General Hospital, Winnipeg, Man.

Graduate nurses for General Staff Duty. Inquiries are invited for these positions in Vancouver General Hospital. 40-hr. wk. Salary: $231 per mo. minimum & $268.50 maximum, plus shift differential for evening & night duty; temporary residence accommodation is available. Applications should be accompanied by letter of acceptance of registration in B.C. from Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., General Hospital, Vancouver 9, B.C.

Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience, Matron, Terrace & District Hospital, Terrace, British Columbia.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses. Salary: $182.43 (one hundred eighty-two dollars & forty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day; 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & post-graduate program. Full Maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information, apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Quebec.

Graduate Nurses offered a six-month post-graduate course in Tuberculosis. Maintenance and salary as for general staff nurses; opportunity for permanent employment if desired. Spring and fall classes. For further information apply Baker Memorial Sanatorium, Calgary, Alberta.

General Duty Nurses for modern 75-bed Hospital. Basic salary $170, plus maintenance. Apply Administrator, Dufferin Area Hospital, Orangeville, Ont.

McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONT.

Requires

A qualified staff for the following positions:

OBSTETRIC SUPERVISOR AND INSTRUCTOR
SUPERVISOR FOR A 20-BED ISOLATION UNIT
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Gross salary commensurate with experience, 28 days vacation after one year, 8 statutory holidays, sick leave accumulative to 60 days; Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped and staffed wing with extensive renovation program progressing in the old section.

APPLY DIRECTOR OF NURSING

Registered Nurses for 60-bed hospital, starting salary $160 plus full maintenance. 8-hr. duty; 28 days vacation; pleasant surroundings with excellent residence across from hospital; increment after 1 yr. service for 3-yrs. Apply Supt. of Nurses, Alexandra Marine & General Hospital, Goderich, Ont.

Registered and Non-Registered Nurses, General Duty. Salaries: Registered Nurses, $160. per mo. with full maintenance; others according to experience; 8-hr. rotating shifts with 1 day off each wk. and an extra day every second wk. Vacation and sick allowance — each 1 and ½ days monthly. Complete new hospital unit under construction. Apply: Supt., Lady Minto Hospital, Cochrane, Ont.

Registered Nurses for General Duty & Operating Room. Busy 70-bed hospital. Commencing salary: $180 & up. Good personnel policies. Apply Supt., Ross Memorial Hospital, Lindsay, Ont.

Registered Nurses for new 30-bed hospital. R.N.A.B.C. policies in effect. Apply Matron Creston Valley Hospital, Creston, B.C.

Graduate Nurses for General Duty. Living-in accommodation if desired. Apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurse (1) immediately — Matron & Registered Nurse April 1. Modern, well equipped 7-bed hospital, newly opened in summer. Salary: Registered Nurse, $210; Matron, $255; both with $5 extra for each 6 mos. previous experience. Semi-annual increments of $5 to maximum of $260 & $305. Friendly, progressive town. Recreation includes swimming, tennis, boating, dancing, skating, skiing, good theatre. Apply Sec., Union Hospital, Rockglen, Sask.

General Duty Nurses for modern, well equipped hospital. Salary: $195 — increases as to merit after 6 mos. 44-hr. wk. Apply Director of Nurses, General Hospital, Sudbury, Ontario.

General Duty Nurses (4) — Registered or Graduate — for 45-bed hospital. 8-hr. shift; 48-hr. wk. Salary: $210 per mo. gross. Increase of $5.00 per mo. after 6 mos. service. 3 wks. holiday with pay after 1 yr. service. Modern nurses' residence. Transportation refunded. Daily bus facilities to North Battleford & Saskatoon. Apply Matron, Union Hospital, Meadow Lake, Sask.

General Duty Nurses for 430-bed hospital. Salary: $230-260. Credit for past experience. Annual increments. 40-hr. wk. Statutory holidays; 28 days annual vacation. Cumulative sick leave. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

CANADIAN RED CROSS SOCIETY

invites applications for ADMINISTRATIVE and STAFF positions in HOSPITAL, PUBLIC HEALTH NURSING SERVICES, and BLOOD TRANSFUSION SERVICE for various parts of Canada.

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Registered Nurses for 398-bed non-sectarian general hospital with School of Nursing, full or part-time. Excellent opportunity for study at nearby Western Reserve University. Starting salary: $240-260, based on experience, plus $1.00 per diem for evening or night duty. **Operating Room Nurses** $10 per mo. additional; two weeks vacation; 6 holidays; 10 days sick leave. We will assist you in finding living accommodations. For detailed personnel policies write: Director of Nursing, Mount Sinai Hospital, 1800 East 105th St., Cleveland 6, Ohio.

General Duty Nurses and **Supervisor for 3:00 p.m. to 11:00 p.m.** to complete staff in new hospital. Good salary and personnel policies. Apply: Director of Nurses, Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

Graduate Nurses for 50-bed Hospital on Vancouver Island. Salary $234 gross. Single room living accommodation in cottages adjacent to the sea; recreation available in tennis, swimming, boating and fishing. Hospital located near bus route within easy driving distance of Victoria. Further particulars on writing to Director of Nursing, Queen Alexandra Solarium for Crippled Children, Cobble Hill, B.C., stating age and qualifications.

Clinical Instructor for Nursing Arts, Pediatric Area in Modern 400-bed hospital. Salary commensurate with experience; applications are now being considered. Address correspondence to: Director of Nursing, Kitchener-Waterloo Hospital, Kitchener, Ont.

Graduate Nurses for completely modern West Coast hospital. Salary: $230. per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after first yr. Also **Evening Supervisor,** 4-12, salary commences at $265. Also **Charge Nurse,** 25-bed ward combined female surgery and obstetrics. Salary commences at $265. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, British Columbia.

Maternity Nurses for small general hospital. Salary $105 with full maintenance; 44-hr. wk; 8-hr. duty; rotating shifts; yearly increments and other benefits. Apply, Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

Matron for Chronic and Convalescent Hospital, to be opened in May, 1955, duties: securing personnel, contacting applicants, and public relations, to commence almost immediately. Must have Christian interest in people, Lutheran preferred, also ability to speak German. Apply, stating qualifications, salary expected etc., to: The Lutheran Home Society, 9911 - 146 St. Edmonton, Alberta.

Nursing Supervisor for active treatment wards at Manitoba Sanatorium, Ninette, Manitoba. Preference for previous supervisory experience and chest surgical nursing experience. Salary range: $245 - 265 per mo. Board, room and laundry in single rooms new Nurses' Home supplied for $45 per mo. Generous vacation with pay, group insurance, all statutory holidays and other employee benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

REGISTERED NURSES

Required by The Provincial Government of Newfoundland

DEPARTMENT OF HEALTH

For **General Duty as Staff Nurses** in small hospitals ranging from 6 to 32 beds. Salary commences at $2200.00 per annum on the scale $2200-100-2300.

Accommodation is supplied in the hospitals at the rate of $40.00 monthly. Uniforms and laundry services are provided free. Annual vacation is 24 working days and sick leave with pay is also granted.

These hospitals are situated throughout the province in the more thickly populated settlements. The climate is temperate with its mild winters and cool summers where various types of recreation are available during both seasons.

Applications with full details should be addressed to:

The Director of Nurses, Newfoundland Department of Health, St. John's, Newfoundland.

Matron for fully modern 30-bed hospital. Duties to commence immediately. Private 3-room suite; 4 wks annual vacation with pay after 1 yr. service; all statutory holidays. All books done by Secretary-Treasurer. Apply stating age, qualifications and salary expected to Robert G. Keast, Sec.-Treas., Roblin District Hospital, Roblin, Manitoba.

Registered Nurses (2) for fully modern 30-bed hospital. Salary: $175 per mo. with full maintenance and increases; separate living quarters; usual vacation schedule and all statutory holidays. Apply: Robert G. Keast, Sec.-Treas., Roblin District Hospital, Roblin, Manitoba.

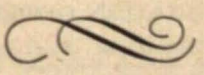
General Duty Nurses for 200-bed general hospital with all graduate staff. Salary: $11 ($240) to $12.60 ($277.20) per day; 40-hr. wk.; p.m. and night bonus; usual paid benefits; credit given for previous experience; promotions made from staff; quarters available next to hospital at $18 per mo.; excellent transportation to all areas. Send snapshot, references, and state qualifications. Each letter will be given my individual attention. Send applications to: Director of Nurses, Doctors Hospital, 12345 Cedar Road, Cleveland, Ohio, U.S.A.

Assistant Head Nurses. Good personnel policies; pension plan available. Apply: Director, Shriners Hospital for Crippled Children, Montreal, Quebec.

A Six months' Postgraduate Course in Plastic Surgery commences on April 1st., and **Canadian Trained Nurses** are invited to apply. Full staff nurses' salary (£360 x £12.10.0 to £460, less £135, board residence) paid while on course. Successful candidates must pay their own fare to England. The posts, (Plastic Surgery, Jaw Injuries and Burns Centre, St. Lawrence Hospital, Chepstow, Mon., with 100 Plastic Surgery, 50 Orthopaedic beds) afford an opportunity of seeing something of England and gaining experience in Plastic Surgery work. Write, stating age, experience, qualifications and two references to: T. A. Jones, Group Secretary, 64 Cardiff Road, Newport, Monmouthshire.

Day Supervisor for 35-bed general hospital near Toronto. Supervisory experience essential. Post-graduate training in administration of nursing service preferred. Apply to Supt., Stevenson Memorial Hospital, Alliston, Ont.

Operating Room Nurse with Post-Graduate Training. For full particulars apply: Director of Nurses, Jeffery Hale's Hospital, Quebec City, Quebec.



Official Directory

CANADIAN NURSES' ASSOCIATION

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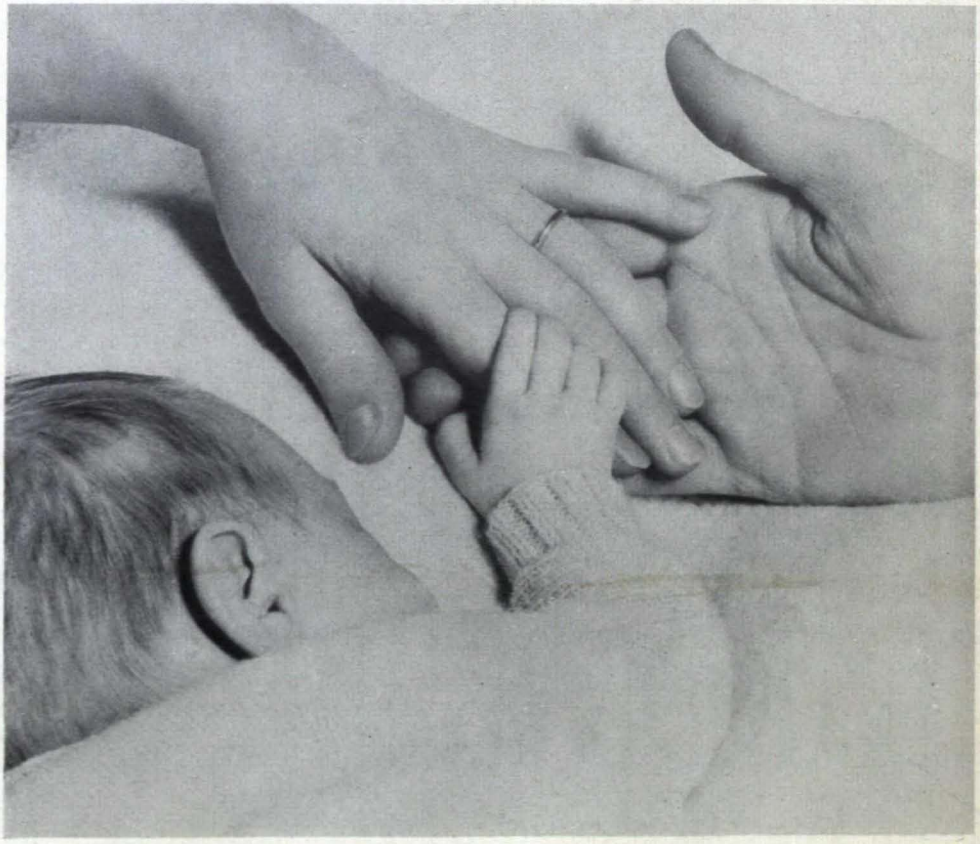

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